

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar for burial, cremation, or removal, and in any event within 72 hours after death.

# MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

Items 1, 8 Film 6216 6-10-57 et

## CERTIFICATE OF DEATH

Reg. Dist. No.

04755

1. PLACE OF DEATH a. COUNTY <b>ANNE ARUNDEL</b> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>MARYLAND</b> b. COUNTY <b>A.A.CO.</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>BASETOWN</b>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>ANNAPOLIS</b>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>ANNE ARUNDEL GENERAL</b>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Middle Last <b>Premature Baby Aldrich</b>		4. DATE OF DEATH Month Day Year <b>MAY 21 1957</b>	
5. SEX <b>M</b>	6. COLOR OR RACE <b>C</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>May 21, 1957</b>
9. AGE (In years last birthday) yn.		10. IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min. <b>7</b>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10b. KIND OF BUSINESS OR INDUSTRY	
11. BIRTHPLACE (State or foreign country) <b>ANNAPOLIS, MD, U.S.A</b>		12. CITIZEN OF WHAT COUNTRY?	
13. FATHER'S NAME <b>Issiah Aldrich</b>		14. MOTHER'S MAIDEN NAME <b>Mildred Johnson</b>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) [If yes, give war or dates of service]		16. SOCIAL SECURITY NO.	
17. INFORMANT <b>JAMES JOHNSON</b>		Address <b>729 Chester Ave</b>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>776X</b> DUE TO <b>Prevoluntarily</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <b>19</b>	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office-bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I attended the deceased from <b>5-21-57</b> , 19 <b>57</b> , to <b>5-21-57</b> , 19 <b>57</b> , that I last saw the deceased alive on <b>5-21-57</b> , 19 <b>57</b> , and that death occurred at <b>M</b> , from the causes and on the date stated above.			
ACTUAL SIGNATURE <b>A.T. Allen</b>		ADDRESS (Street, city or town, state) <b>62 Chestnut St</b> DATE SIGNED <b>6-3-57</b>	
PHYSICIAN'S NAME (Type) <b>A.T. ALLEN</b>		<b>Annapolis Md</b>	
22a. BURIAL, CREMATION, REMOVAL (Specify)	22b. DATE THEREOF	22c. NAME OF CEMETERY OR CREMATORY	22d. LOCATION (City, town, or county) (State)
23. FUNERAL DIRECTOR'S SIGNATURE <b>Ethel B. Hicks</b> ADDRESS <b>43 NORTH WEST St. City</b>		24a. REC'D BY REGISTRAR <b>DATE 6/3/57</b>	24b. REGISTRAR'S SIGNATURE

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# CERTIFICATE OF DEATH

MARYLAND STATE DEPARTMENT OF HEALTH - BALTIMORE 18

NAME OF DECEASED JAMES J. JENNISON		DATE OF DEATH JAN 27 1957	
AGE 42		SEX M	
RACE W		EDUCATION H	
OCCUPATION Carpenter		MARITAL STATUS M	
PLACE OF BIRTH BALTIMORE, MD		DATE OF BIRTH JAN 27 1915	
PLACE OF DEATH BALTIMORE, MD		DATE OF DEATH JAN 27 1957	
CAUSE OF DEATH HEART DISEASE		MANNER OF DEATH N	
SIGNATURE OF PHYSICIAN J. J. JENNISON		SIGNATURE OF REGISTRAR J. J. JENNISON	

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TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.  
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# MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

04756

4761

## CERTIFICATE OF DEATH

Reg. Dist. No. 21

1. PLACE OF DEATH a. COUNTY <u>Anne Arundel</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution, residence before admission) o. STATE <u>Maryland</u> b. COUNTY <u>C.C.</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Annapolis</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Annapolis</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) <u>38 Parole St.</u>		d. STREET ADDRESS <u>38 Parole St.</u>	
3. NAME OF DECEASED (Type or print) First <u>Samuel</u> Middle <u>Barnett</u> Last <u>Barnett</u>		4. DATE OF DEATH Month <u>5</u> Day <u>11</u> Year <u>1957</u>	
5. SEX <u>Male</u>	6. COLOR OR RACE <u>Col.</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>7-18-1883</u>
9. AGE (In years last birthday) <u>73</u> yrs.		10. IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Laborer</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Walter McNeel C.C. Co. Md.</u>	
11. BIRTHPLACE (State or foreign country) <u>U.S.A.</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>Unknown</u>		14. MOTHER'S MAIDEN NAME <u>Unknown</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, No, or unknown) <u>No</u> (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. <u>214-052067</u> 17. INFORMANT <u>Phelia Barnett Annapolis, Md.</u> Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Cerebral Hemorrhage</u> <u>331x</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) _____ (c) _____ DUE TO		INTERVAL BETWEEN ONSET AND DEATH	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) _____ 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <u>19</u>	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I attended the deceased from <u>11-26-56</u> , 19____, to <u>5-11-57</u> , 19____, that I last saw the deceased alive on <u>5-11-57</u> , 19____, and that death occurred at <u>1:15</u> M., from the causes and on the date stated above.			
ACTUAL SIGNATURE <u>[Signature]</u> M.D. <u>62</u>		ADDRESS (Street, city or town, state) <u>Eachwood</u> DATE SIGNED <u>5-11-57</u>	
PHYSICIAN'S NAME (Type) <u>A T ALLEN</u>		<u>Annapolis</u>	
22a. BURIAL, CREMATION, REMOVAL (Specify)	22b. DATE THEREOF	22c. NAME OF CEMETERY OR CREMATORY	22d. LOCATION (City, town, or county) (State)
<u>Burial</u>	<u>5-15-57</u>	<u>Mt. Calvary</u>	<u>Annapolis Md.</u>
23. FUNERAL DIRECTOR'S SIGNATURE <u>William Reese, Jr. Annapolis, Md.</u>		24a. REC'D BY REGISTRAR DATE <u>5/13/57</u>	24b. REGISTRAR'S SIGNATURE <u>Dr. Wm. J. Lynch</u>

# CERTIFICATE OF DEATH

MARYLAND STATE DEPARTMENT OF HEALTH - BALTIMORE 10

Name of Deceased: *James Earl Ray*  
 Date of Death: *May 14, 1968*  
 Place of Death: *Prison, St. Louis, Missouri*  
 Cause of Death: *Heart Disease*  
 Age: *35*  
 Sex: *Male*  
 Race: *White*  
 Date of Birth: *May 19, 1933*  
 Place of Birth: *London, England*  
 Date of Admission: *May 14, 1968*  
 Date of Discharge: *May 14, 1968*  
 Date of Death: *May 14, 1968*  
 Date of Burial: *May 14, 1968*  
 Date of Cremation: *May 14, 1968*  
 Date of Interment: *May 14, 1968*  
 Date of Burial: *May 14, 1968*  
 Date of Cremation: *May 14, 1968*  
 Date of Interment: *May 14, 1968*

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Date of Death: *May 14, 1968*  
 Date of Burial: *May 14, 1968*  
 Date of Cremation: *May 14, 1968*  
 Date of Interment: *May 14, 1968*



4762

## CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <i>aa</i> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <i>MD</i> b. COUNTY <i>aa</i>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Annapolis</i>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>x2 Elderswater A.A.C. Md.</i>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <i>all General Hospt</i>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <i>Jacqueline</i> Middle <i>Lee</i> Last <i>Barton</i>		4. DATE OF DEATH Month <i>5</i> Day <i>3</i> Year <i>1957</i>	
5. SEX <i>Female</i>	6. COLOR OR RACE <i>White</i>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <i>5-1-57</i>
9. AGE (In years last birthday) yrs. <i>2</i>		IF UNDER 1 YEAR Months <i>2</i> Days <i>2</i> Hours <i>2</i> Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>None</i>		10b. KIND OF BUSINESS OR INDUSTRY <i>None</i>	
11. BIRTHPLACE (State or foreign country) <i>Annapolis Md</i>		12. CITIZEN OF WHAT COUNTRY? <i>U.S.A.</i>	
13. FATHER'S NAME <i>John A. Barton</i>		14. MOTHER'S MAIDEN NAME <i>Rosemarie Riggan</i>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <i>(If yes, give war or dates of service)</i>		16. SOCIAL SECURITY NO. <i>John A. Barton</i>	
17. INFORMANT <i>John A. Barton</i>		Address <i>(2)</i>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>Pneumonia</i> 774x DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <i>Hyaline Membrane Disease of lung</i> (c) <i>Asphyxia and Puerperal</i> 2 days 2 days			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <i>763.5</i>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. p. m. 19		20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <i>5/1</i> , 19 <i>57</i> , to <i>5/3</i> , 19 <i>57</i> , that I last saw the deceased alive on <i>5/3</i> , 19 <i>57</i> , and that death occurred at <i>2:25 PM</i> , from the causes and on the date stated above. ADDRESS (Street, city or town, state) DATE SIGNED <i>95 Cathedral St Annapolis Md</i> ACTUAL SIGNATURE <i>Philip Briscoe</i> M.D. PHYSICIAN'S NAME (Type) <i>PHILIP BRISCOE</i> <i>95 CATHEDRAL ST. ANNAPOLIS MD</i>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <i>Burial</i>	22b. DATE THEREOF <i>5-4-57</i>	22c. NAME OF CEMETERY OR CREMATORY <i>St. Marys</i>	22d. LOCATION (City, town, or county) (State) <i>Annapolis Md</i>
23. FUNERAL DIRECTOR'S SIGNATURE <i>John M. Long</i>		24a. REC'D BY REGISTRAR DATE <i>5/6/57</i>	24b. REGISTRAR'S SIGNATURE <i>J. J. J. J.</i>

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be attached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with the registrar price, burial, cremation, or removal, and in any event within 72 hours after death.

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Items 18, 20 &amp; 21 Film 216 8-3-57

## MEDICAL EXAMINER'S CERTIFICATE OF DEATH

4763

Items 7, 8, 11, 12, 13, 14, 17 Film G216 5-31-57 et Reg. Dist. No. 21

1. PLACE OF DEATH a. COUNTY <b>Anne Arundel</b> <b>MARYLAND</b>				2. USUAL RESIDENCE (Where deceased lived. If Institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Anne Arundel</b>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Annapolis</b>				c. LENGTH OF STAY IN 1b			
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <b>Anne Arundel General Hospital</b>				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First <b>FREDERICK</b> Middle <b>BLUNT</b> Last <b>BLUNT</b>				4. DATE OF DEATH Month <b>May</b> Day <b>13</b> Year <b>19 57</b>			
5. SEX <b>Male</b>	6. COLOR OR RACE <b>Colored</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>May 1, 1956</b>		9. AGE (In years last birthday) <b>1</b> yrs.	IF UNDER 1 YEAR Months <b>1</b> Days <b>13</b>	IF UNDER 24 HRS. Hours <b>13</b> Min. <b>57</b>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)			10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) <b>Washington, D.C.</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>
13. FATHER'S NAME <b>William Blunt</b>				14. MOTHER'S MAIDEN NAME <b>Rosie Lee Makell</b>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown)		16. SOCIAL SECURITY NO.		17. INFORMANT <b>Wm. Blunt - Churchton, Md.</b>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Craniocerebral Injury</b> <b>902.0</b> <b>DUE TO</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <b>Bronchopneumonia</b> DUE TO <b>due to aspirated stomach content.</b> (c)							INTERVAL BETWEEN ONSET AND DEATH
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>
20a. EXTERNAL CAUSE WAS PRIMARY <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <b>Fell out of bed</b>					
20c. TIME OF INJURY Month, Day, Year <b>8:00 a.m. 5/13/57</b>		20d. INJURY OCCURRED While of work <input type="checkbox"/> Not while of work <input checked="" type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <b>Home</b>		20f. (City or town) (County) (State) <b>Churchton A.A. Md.</b>	
21. I certify that I took charge of the remains described above, held on Autopsy <input checked="" type="checkbox"/> Inspection <input type="checkbox"/> Inquiry <input type="checkbox"/> and find that death resulted from: Natural causes <input type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined cause <input type="checkbox"/> .							
ACTUAL SIGNATURE <b>Paul F. Guerin</b>				M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/>			
EXAMINER'S NAME (Type) <b>Paul F. Guerin, M.D.</b>				ASSISTANT MEDICAL EXAMINER <input checked="" type="checkbox"/>			
DEPUTY MEDICAL EXAMINER <input type="checkbox"/>				DATE SIGNED <b>5/14/57</b>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>5-16-57</b>		22b. DATE THEREOF		22c. NAME OF CEMETERY OR CREMATORY <b>Franklin Cemetery</b>		22d. LOCATION (City, town, or county) (State) <b>Churchton Md.</b>	
23. FUNERAL DIRECTOR'S SIGNATURE <b>Wm Reese 108 Wb Wash. St.</b>				ADDRESS		24a. REC'D BY REGISTRAR DATE <b>5/16/57</b>	
				24b. REGISTRAR'S SIGNATURE <b>Dr. Wm J. French</b>			

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.

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RECEIVED

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.  
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# MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

## 4790 CERTIFICATE OF DEATH

04759

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <i>aa</i> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <i>md</i> b. COUNTY <i>aa</i>	
5. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Friendship</i>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Friendship</i> x o	
6. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION		d. STREET ADDRESS	
3. NAME OF DECEASED (Type or print) <i>Wm Hamilton Boyd</i>		4. DATE OF DEATH Month <i>May</i> Day <i>7</i> Year <i>1957</i>	
5. SEX <i>M</i>	6. COLOR OR RACE <i>W</i>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <i>May 11, 1888</i>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>Farmer</i>		10b. KIND OF BUSINESS OR INDUSTRY <i>Farm</i>	
11. BIRTHPLACE (State or foreign country) <i>MD</i>		12. CITIZEN OF WHAT COUNTRY?	
13. FATHER'S NAME <i>William Boyd</i>		14. MOTHER'S MAIDEN NAME <i>Marjorie Kelymple</i>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO.	
17. INFORMANT <i>Wm. H. Boyd</i>		Address <i>Friendship MD</i>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c.)] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>Cardio vascular renal</i> 442X DUE TO <i>ischemic</i> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour <i>a. m.</i> <i>19</i> p. m.		20d. INJURY OCCURRED While <input checked="" type="checkbox"/> at work Not while <input type="checkbox"/> at work	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <i>Jan 1</i> , 19 <i>57</i> , to <i>May 7</i> , 19 <i>57</i> , that I last saw the deceased alive on <i>5/7/57</i> , 19 <i>57</i> , and that death occurred at <i>5:15</i> AM, from the causes and on the date stated above.			
ACTUAL SIGNATURE <i>H. W. Ward</i>		M.D. <i>Owings MD</i> DATE SIGNED <i>5/7/57</i>	
PHYSICIAN'S NAME (Type) <i>H. W. Ward</i>		<i>Owings, Maryland</i>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <i>Burial</i>	22b. DATE THEREOF <i>May 9, 1957</i>	22c. NAME OF CEMETERY OR CREMATORY <i>Friendship Cemetery</i>	22d. LOCATION (City, town, or county) (State) <i>Friendship MD</i>
23. FUNERAL DIRECTOR'S SIGNATURE <i>W. H. Hutchins</i>		ADDRESS <i>Owings, Maryland</i>	
24a. RECEIVED BY REGISTRAR DATE <i>5/8/57</i>		24b. REGISTRAR'S SIGNATURE <i>H. W. Ward</i>	



## MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE 18

# MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

## MEDICAL EXAMINER'S CERTIFICATE OF DEATH

04760

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>Anne Arundel</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE <u>Same</u> b. COUNTY <u>Same</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>P.O. Severna Park</u>				c. LENGTH OF STAY IN 1b <u>5 years</u>			
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>Oak Road Circle, Manhattan Beach,</u>				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First Middle Last <u>Olevia E. Bromley</u>				4. DATE OF DEATH Month Day Year <u>May 25th. 1957 19</u>			
5. SEX <u>F.</u>	6. COLOR OR RACE <u>W.</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>9/17/1900</u>		9. AGE (in years last birthday) <u>56</u> yrs.	IF UNDER 1 YEAR Months Days	IF UNDER 24 HRS. Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>housewife</u>			10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) <u>Dorchester County, Md.</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>
13. FATHER'S NAME <u>J. Francis Hearn</u>				14. MOTHER'S MAIDEN NAME <u>Henrietta Tyler</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (If yes, no, or unknown) <u>No</u>		16. SOCIAL SECURITY NO. <u>None</u>		17. INFORMANT <u>Mr. John A. Bromley (husband)</u>		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Cirrhosis &amp; Fatty Infiltration of Liver</u> <u>581.0</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) _____ DUE TO (c) _____							INTERVAL BETWEEN ONSET AND DEATH
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <u>19</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> Inspection <input type="checkbox"/> Inquiry <input type="checkbox"/> and find that death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined cause <input type="checkbox"/> .							
ACTUAL SIGNATURE <u>William Updegraff</u> M.D.				CHIEF MEDICAL EXAMINER <input type="checkbox"/>		DATE SIGNED	
EXAMINER'S NAME (Type) <u>William Updegraff</u>				ASSISTANT MEDICAL EXAMINER <input checked="" type="checkbox"/>		DEPUTY MEDICAL EXAMINER <input type="checkbox"/>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>5-28-57</u>		22c. NAME OF CEMETERY OR CREMATORY <u>Dorchester Park Memorial Cambridge Md.</u>		22d. LOCATION (City, town, or county) (State) <u>Md.</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>John M. Taylor Sons</u>				ADDRESS <u>Annapolis Md</u>		24a. REC'D BY REGISTRAR DATE <u>5/28/57</u>	
				24b. REGISTRAR'S SIGNATURE <u>U. Daniel</u>			

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please enclose the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

181

BUREAU V. S.

MAY 29 1957

RECEIVED

4792

## CERTIFICATE OF DEATH

Reg. Dist. No. 28

1. PLACE OF DEATH o. COUNTY <b>Anne Arundel</b> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE <b>Maryland</b> b. COUNTY <b>Baltimore City</b>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Crownsville</b>				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Baltimore City</b> 3V01.4 ✓			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>Crownsville State Hospital</b>				d. STREET ADDRESS <b>1926 E. Eager Street</b>			
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>							
3. NAME OF DECEASED (Type or print) First <b>Anna</b> Middle <b>Mae</b> Last <b>Broughton</b>				4. DATE OF DEATH Month <b>5</b> Day <b>7</b> Year <b>1957</b>			
5. SEX <b>Female</b>		6. COLOR OR RACE <b>Negro</b>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <b>Not given</b>	
9. AGE (In years last birthday) <b>52?</b> yrs.		IF UNDER 1 YEAR Months <b>-</b> Days <b>-</b> Hours <b>-</b> Min. <b>-</b>		10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Crab picker</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>- -</b>	
11. BIRTHPLACE (State or foreign country) <b>Maryland</b>				12. CITIZEN OF WHAT COUNTRY? <b>U. S.</b>			
13. FATHER'S NAME <b>John Henry Scarber</b>				14. MOTHER'S MAIDEN NAME <b>Josephine Scarber</b>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (If yes, no, or unknown) <b>Unk.</b>		16. SOCIAL SECURITY NO. <b>Unk.</b>		17. INFORMANT <b>Hospital Records</b>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Bronchopneumonia and Uremia, etc.</b> <b>332X</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <b>Cerebral Thrombosis</b> DUE TO (c) _____				INTERVAL BETWEEN ONSET AND DEATH			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <b>443X</b> <b>Hypertensive Cardiovascular Disease, Decubitus ulcer</b>				19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <b>19</b>				20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> of work of work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town) (County) (State)							
21. I certify that I attended the deceased from <b>2/28</b> , 19 <b>57</b> , to <b>5/7</b> , 19 <b>57</b> , that I last saw the deceased alive on <b>5/7</b> , 19 <b>57</b> , and that death occurred at <b>7:30 p.m.</b> from the causes and on the date stated above. ADDRESS (Street, city or town, state) <b>Crownsville, Md.</b> DATE SIGNED <b>5/8/57</b> ACTUAL SIGNATURE <b>Lionel McHenry Mapp</b> M.D. PHYSICIAN'S NAME (Type) <b>Lionel McHenry Mapp, M. D.</b>							
22a. BURIAL, CREMATION, RESURRACTION (Specify)		22b. DATE THEREOF		22c. NAME OF CEMETERY OR CREMATORY		22d. LOCATION (City, town, or county) (State)	
<b>5/14/57</b>		<b>5/14/57</b>		<b>Crownsville State Hosp.</b>		<b>Crownsville Md</b>	
23. FUNERAL DIRECTOR'S SIGNATURE <b>Ralph S. Mapp</b>				24a. REC'D BY REGISTRAR DATE <b>5-14-57</b>		24b. REGISTRAR'S SIGNATURE <b>11 M Joco</b>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the general director, page 3 should be attached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

CERTIFICATE OF DEATH

BUREAU V. 2

1957

RECEIVED



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

## MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

04762

4793

## CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH o. COUNTY <i>ANNE ARUNDEL</i> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE <i>MARYLAND</i> b. COUNTY <i>AA</i>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>RURAL GLEN BURNIE</i>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>RURAL GLEN BURNIE</i>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <i>Powhattan Rd.</i>		d. STREET ADDRESS <i>Powhattan Rd.</i>	
3. NAME OF DECEASED (Type or print) First <i>MARGARET</i> Middle <i>G.</i> Last <i>BURY</i>		4. DATE OF DEATH Month <i>MAY 24</i> Day <i>19</i> Year <i>1957</i>	
5. SEX <i>FEMALE</i>	6. COLOR OR RACE <i>White</i>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <i>NOV 25, 1878</i>
9. AGE (In years lost birthday) <i>78</i> yrs.		10. IF UNDER 1 YEAR IF UNDER 24 HRS. Months <i>7</i> Days <i>8</i> Hours <i>19</i> Min. <i>57</i>	
11a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>LAY-OUT OPERATOR</i>		11b. KIND OF BUSINESS OR INDUSTRY <i>Brush MFG.</i>	
11c. BIRTHPLACE (State or foreign country) <i>BALTIMORE Md.</i>		12. CITIZEN OF WHAT COUNTRY? <i>U.S.A.</i>	
13. FATHER'S NAME <i>ADAM Gehring</i>		14. MOTHER'S MAIDEN NAME <i>CAROLINE Hinkel</i>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <i>No</i> (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. <i>213-05-3122</i>	
17. INFORMANT <i>MR. CHARLES ARNOLD CHRISTIAN ST.</i>		Address <i>2219</i> (23)	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <i>Acute coronary thrombosis</i> <i>420.1</i> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <i>Hypertensive Cardio-vascular disease</i> DUE TO (c) <i>2 years-</i>		INTERVAL BETWEEN ONSET AND DEATH <i>1 hour</i>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <i>none</i>		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <i>19</i>		20d. INJURY OCCURRED While of work <input type="checkbox"/> Not while of work <input checked="" type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <i>Sept. 10, 1955</i> to <i>May 24, 1957</i> , that I last saw the deceased alive on <i>Sept. 10, 1957</i> , and that death occurred at <i>10:15 P.M.</i> , from the causes and on the date stated above.			
ACTUAL SIGNATURE <i>R.M. McLaughlin</i>		ADDRESS (Street, city or town, state) <i>Mountain Road, Pasadena May 24, 1957</i>	
PHYSICIAN'S NAME (Type) <i>R.M. McLaughlin, M.D.</i>		DATE SIGNED	
22a. BURIAL, CREMATION, REMOVAL (Specify) <i>Burial</i>		22b. DATE THEREOF <i>May 28, 1957</i>	
22c. NAME OF CEMETERY OR CREMATORY <i>Landon Park Cem.</i>		22d. LOCATION (City, town, or county) (State) <i>Balto. Maryland</i>	
23. FUNERAL DIRECTOR'S SIGNATURE <i>S. Truman Schulz</i>		ADDRESS <i>3312 Frederick Ave. (29)</i>	
24a. REC'D BY REGISTRAR <i>DATE MAY 28 1957</i>		24b. REGISTRAR'S SIGNATURE <i>L.J. Sedberry</i>	

# CERTIFICATE OF DEATH

MARYLAND STATE DEPARTMENT OF HEALTH - BALTIMORE, MD

DATE OF DEATH

1. NAME, ADDRESS, and other information of the deceased

2. PLACE OF DEATH

3. CAUSE OF DEATH (to be filled in by the physician)

4. MANNER OF DEATH

5. TIME OF DEATH (to be filled in by the physician)

6. AGED

7. SEX

8. RACE

9. OCCUPATION

10. MARITAL STATUS

11. EDUCATION

12. RELIGION

13. PREVIOUS ILLNESS

14. PREVIOUS SURGERY

15. PREVIOUS TRAUMA

16. PREVIOUS DRUGS

17. PREVIOUS ALCOHOL

18. PREVIOUS TOBACCO

19. PREVIOUS OTHER

20. PREVIOUS OTHER

21. PREVIOUS OTHER

22. PREVIOUS OTHER

23. PREVIOUS OTHER

24. PREVIOUS OTHER

25. PREVIOUS OTHER

26. PREVIOUS OTHER

27. PREVIOUS OTHER

28. PREVIOUS OTHER

29. PREVIOUS OTHER

30. PREVIOUS OTHER

31. PREVIOUS OTHER

32. PREVIOUS OTHER

33. PREVIOUS OTHER

34. PREVIOUS OTHER

35. PREVIOUS OTHER

36. PREVIOUS OTHER

37. PREVIOUS OTHER

38. PREVIOUS OTHER

39. PREVIOUS OTHER

40. PREVIOUS OTHER

BUREAU V. 3

JAY 28 1957

RECEIVED

## 4791 CERTIFICATE OF DEATH

Reg. Dist. No.

## 1. PLACE OF DEATH:

COUNTY

Anne Arundel

MARYLAND

CITY (If outside corporate limits, write RURAL OR and give nearest town)

LENGTH OF STAY (in this place)

HOSPITAL OR INSTITUTION OR STREET ADDRESS

Box 195 Magathy Beach

## 2. USUAL RESIDENCE (HOME) OF DECEASED:

STATE

Maryland

COUNTY

A.A.

CITY (If outside corporate limits, write RURAL, and give nearest town) OR TOWN

X0 Magathy Beach

STREET ADDRESS

(If rural give location)

Box 195

## 3. NAME OF DECEASED:

(First)

JOHN

(Middle)

HENRY

(Last)

CHAMBERS

4. DATE OF DEATH:

(Month)

MAY

(Day)

18

(Year)

19 57

## 5. SEX:

M

## 6. COLOR OR RACE:

W

## 7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify):

W

## 8. DATE OF BIRTH:

Aug. 2, 1884

## 9. AGE last birthday:

72 yrs.

IF UNDER 1 YEAR

Months

Days

Hours

Min.

## 10a. USUAL OCCUPATION. Give kind of work done during most of working life, even if retired):

Maritime

## 10b. KIND OF BUSINESS OR INDUSTRY:

Retired

## 11. BIRTHPLACE (State or foreign country):

Maryland

## 12. CITIZEN OF WHAT COUNTRY?

## 13. FATHER'S NAME:

William R. Chambers

## 14. MOTHER'S MAIDEN NAME:

Catherine Bowers

## 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.) (If Yes, give war or dates of service)

No

## 16. SOCIAL SECURITY No.:

## 17. INFORMANT &amp; ADDRESS:

Family

Same

## 18. MEDICAL CERTIFICATION

## 1. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH

Immediate cause

(a)

DUE TO

CARCINOMA RECTUM

Antecedent cause(s)

Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last.

(b)

DUE TO

(c)

Interval Between Onset And Death

2 YEARS

## 11. OTHER SIGNIFICANT CONDITIONS

Conditions contributing to the death but not related to the disease or condition causing death.

## 19a. DATE OF OPERATION:

## 19b. MAJOR FINDINGS OF OPERATION

## 20. AUTOPSY?

Yes ☐ No ☐

## 21. ACCIDENT SUICIDE HOMICIDE

(Specify)

PLACE (Home, farm, factory, street, office bldg., etc.) OF INJURY

(CITY OR TOWN)

(COUNTY)

(STATE)

TIME (Month) (Day) (Year) (Hour) OF INJURY

INJURY OCCURRED While at Work ☐ Not While At Work ☐

HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from 6/11, 1954, to 5/18, 1957, that I last saw the deceased

alive on 5/16, 1957, and that death occurred at 2:15 AM, from the causes and on the date stated above.

SIGNATURE

(Degree or title)

ADDRESS

DATE SIGNED

J. Brady Smith, M.D.

RIVIERA BEACH, MD.

5/18/57

## 23. BURIAL, CREMATION, REMOVAL (Specify)

## DATE THEREOF

## NAME OF CEMETERY OR CREMATORY

## LOCATION (City, town, or county)

(State)

DATE REC'D BY LOCAL REGISTRAR

REGISTRAR'S SIGNATURE

## 24. FUNERAL DIRECTOR

ADDRESS

5/20/57

A. W. Hedrick

McCully Funeral Homes 130 E. Fort Ave.

MARGIN RESERVED FOR BINDING

BUREAU V. 31

1957

RECEIVED

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

04764

4764

CERTIFICATE OF DEATH

Reg. Dist. No.

21

1. PLACE OF DEATH a. COUNTY <u>Anne Arundel</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission). o. STATE <u>Maryland</u> b. COUNTY <u>Anne Arundel</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Annapolis</u>				c. LENGTH OF STAY IN 1b <u>D.O.A.</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) <u>Anne Arundel General Hospital</u>				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First <u>Creighton</u> Middle <u>M.</u> Last <u>Churchill</u>				4. DATE OF DEATH Month <u>May</u> Day <u>26</u> Year <u>1957</u>			
5. SEX <u>Male</u>		6. COLOR OR RACE <u>White</u>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>Dec. 28, 1881</u>	
9. AGE (In years last birthday) <u>75</u> yrs.		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Clark (ret.)</u>		11. BIRTHPLACE (State or foreign country) <u>Las Vegas, New Mexico</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>James C. Churchill</u>				14. MOTHER'S MAIDEN NAME <u>Virginia Madison</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>No</u>		16. SOCIAL SECURITY NO. <u>121-01-2576</u>		17. INFORMANT <u>Ms. Ida Churchill</u>		Address <u>Same As #2</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>420.1</u> DUE TO <u>Coronary Thrombosis</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>                    </u> DUE TO <u>                    </u> (c) <u>                    </u> DUE TO <u>                    </u> PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>                    </u> INTERVAL BETWEEN ONSET AND DEATH <u>                    </u>							
MEDICAL CERTIFICATION 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) 20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <u>19</u> 20d. INJURY OCCURRED While <input type="checkbox"/> at work Not while <input type="checkbox"/> at work <input type="checkbox"/> 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) 20f. (City or town) (County) (State)							
21. I certify that I attended the deceased from <u>                    </u> , 19 <u>                    </u> , to <u>                    </u> , 19 <u>                    </u> , that I last saw the deceased alive on <u>                    </u> , 19 <u>                    </u> , and that death occurred at <u>9:30</u> M, from the causes and on the date stated above. ADDRESS (Street, city or town, state) <u>6 SHAW ST. ANNAPOLIS, MD.</u> DATE SIGNED <u>5/26/57</u> ACTUAL SIGNATURE <u>James R. Martin</u> M.D. PHYSICIAN'S NAME (Type) <u>JAMES R. MARTIN</u>							
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>May 28, 1957</u>		22c. NAME OF CEMETERY OR CREMATORY <u>Rock Creek Cem.</u>		22d. LOCATION (City, town, or county) (State) <u>Washington, D.C.</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>                    </u> ADDRESS <u>Glen Burnie, Md.</u>				24a. REC'D BY REGISTRAR <u>                    </u> DATE <u>MAY 29 1957</u>		24b. REGISTRAR'S SIGNATURE <u>                    </u>	





TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

# MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

4795

## CERTIFICATE OF DEATH

Reg. Dist. No.

04765

1. PLACE OF DEATH a. COUNTY <u>Anne Arundel</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Md.</u> b. COUNTY <u>A.A.C.</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Rural Annapolis</u>				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Rural Annapolis</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Wild Rose Shores</u>				d. STREET ADDRESS <u>Wild Rose Shores</u>			
3. NAME OF DECEASED (Type or print) <u>MARGUERITE MARY COCKADAY</u>				4. DATE OF DEATH <u>MAY 11 1957</u>			
5. SEX <u>FEMALE</u>	6. COLOR OR RACE <u>WHITE</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>OCT. 30, 1903</u>	9. AGE (In years last birthday) <u>53</u> yrs.	IF UNDER 1 YEAR Months Days Hours Min.	IF UNDER 24 HRS. Hours Min.	e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>1 SOCIAL WORKER A.A.CO WELFARE DEPT.</u>				10b. KIND OF BUSINESS OR INDUSTRY <u>NEW YORK</u>		11. BIRTHPLACE (State or foreign country) <u>U.S.A.</u>	
12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>				13. FATHER'S NAME <u>WILLIAM DUGGAN</u>			
14. MOTHER'S MAIDEN NAME <u>MARY O'KEEFE</u>				15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)			
16. SOCIAL SECURITY NO.				17. INFORMANT <u>LAURENCE M. COCKADAY #2</u> Address			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>153X</u> DUE TO <u>153X</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>METASTATIC CARCINOMA OF COLON</u> DUE TO <u>6 YRS.</u> (c) _____						INTERVAL BETWEEN ONSET AND DEATH <u>3 MONTHS</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) _____							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. p. m. <u>19</u>				20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town) _____ (County) _____ (State) _____				20g. (City or town) _____ (County) _____ (State) _____			
21. I certify that I attended the deceased from <u>JUNE 10, 1955</u> to <u>5/11</u> , 1957, that I last saw the deceased alive on <u>5/11</u> , 1957, and that death occurred at <u>4:45 P.M.</u> from the causes and on the date stated above.							
ACTUAL SIGNATURE <u>Edward H. Beck</u> M.D.				ADDRESS (Street, city or town, state) <u>46 Southgate Ave Annapolis, Md.</u>			
PHYSICIAN'S NAME (Type) <u>Edmund H. Beck</u>				DATE SIGNED <u>5/13/57</u>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>5-14-57</u>		22b. DATE THEREOF <u>5-14-57</u>		22c. NAME OF CEMETERY OR CREMATORY <u>ST. MARY'S CEM.</u>		22d. LOCATION (City, town, or county) <u>ANNAPOLIS MD.</u> (State) <u>MD.</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>JOHN M. TAYLOR, SONS</u>				ADDRESS <u>ANNAPOLIS MD.</u>		24a. REC'D BY REGISTRAR <u>MAY 14 1957</u>	
24b. REGISTRAR'S SIGNATURE <u>J. J. J.</u>				24c. REGISTRAR'S SIGNATURE <u>J. J. J.</u>			



4765

## CERTIFICATE OF DEATH

Reg. Dist. No. 04766

1. PLACE OF DEATH a. COUNTY <u>ANNE ARUNDEL</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE <u>MARYLAND</u> b. COUNTY <u>ANNE ARUNDEL</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>ANNAPOLIS</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>ANNAPOLIS MD.</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>ANN ARUNDEL SENATOR</u>		d. STREET ADDRESS <u>Franklin</u>	
3. NAME OF DECEASED (Type or print) First <u>RICHARD</u> Middle <u>ASBURY</u> Last <u>COLBERT</u>		4. DATE OF DEATH <input checked="" type="checkbox"/> Month <u>MAY</u> Day <u>22</u> Year <u>1957</u>	
5. SEX <u>M</u>	6. COLOR OR RACE <u>C</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>JULY 24, 1895</u>
9. AGE (In years last birthday) <u>61</u> yrs.		10. IF UNDER 1 YEAR: Months <u>6</u> Days <u>22</u> Hours <u>19</u> Min. <u>57</u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Janitor</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>U.S.A.</u>	
11. BIRTHPLACE (State or foreign country) <u>U.S.A.</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>WILLIAM HENRY COLBERT</u>		14. MOTHER'S MAIDEN NAME <u>MARY ELIZABETH HALL</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>NO</u>		16. SOCIAL SECURITY NO. <u>NONE</u>	
17. INFORMANT <u>Lillian A. Colbert</u>		Address <u>11 College Park, Md.</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Hypertensive Cardio-vascular</u> <u>443X</u> DUE TO <u>Dissecting Aortic Failure</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) _____ DUE TO _____ (c) _____			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) _____			
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. _____ p. m. _____ 19 _____	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) _____ (County) _____ (State) _____
21. I certify that I attended the deceased from <u>5-19-57</u> , 19 _____, to <u>5-22-57</u> , 19 _____, that I last saw the deceased alive on <u>5-19-57</u> , 19 _____, and that death occurred at <u>8:00</u> P. M., from the causes and on the date stated above.			
ACTUAL SIGNATURE <u>C. T. Allen</u>		ADDRESS (Street, city or town, state) <u>61 Elizabeth St. Annapolis Md.</u> DATE SIGNED <u>5-28-57</u>	
PHYSICIAN'S NAME (Type) <u>A. T. ALLEN</u>		M.D. <u>annapolis md</u>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>6/26/57</u>	22b. DATE THEREOF	22c. NAME OF CEMETERY OR CREMATORY <u>Brewer Hill</u>	22d. LOCATION (City, town, or county) <u>ANNAPOLIS MD.</u> (State)
23. FUNERAL DIRECTOR'S SIGNATURE <u>Edith S. Hicks</u> ADDRESS <u>H3 NORTHWEST ST.</u>		24a. REC'D BY REGISTRAR <u>5/29/57</u>	24b. REGISTRAR'S SIGNATURE <u>[Signature]</u>

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

# CERTIFICATE OF DEATH

1957

1. NAME OF DECEASED [Faint text]		2. SEX [Faint text]		3. AGE [Faint text]	
4. DATE OF BIRTH [Faint text]		5. PLACE OF BIRTH [Faint text]		6. OCCUPATION [Faint text]	
7. DATE OF DEATH [Faint text]		8. PLACE OF DEATH [Faint text]		9. CAUSE OF DEATH [Faint text]	
10. MEDICAL HISTORY [Faint text]		11. HISTORY OF PRESENT ILLNESS [Faint text]		12. POST-MORTEM EXAMINATION [Faint text]	
13. SIGNATURE OF PHYSICIAN [Faint text]		14. SIGNATURE OF REGISTRAR [Faint text]		15. SIGNATURE OF WITNESSES [Faint text]	
16. SIGNATURE OF DECEASED [Faint text]		17. SIGNATURE OF NEXT OF KIN [Faint text]		18. SIGNATURE OF CLERK [Faint text]	
19. SIGNATURE OF CHURCH CLERK [Faint text]		20. SIGNATURE OF MINISTER [Faint text]		21. SIGNATURE OF RABBI [Faint text]	
22. SIGNATURE OF OTHER [Faint text]		23. SIGNATURE OF OTHER [Faint text]		24. SIGNATURE OF OTHER [Faint text]	
25. SIGNATURE OF OTHER [Faint text]		26. SIGNATURE OF OTHER [Faint text]		27. SIGNATURE OF OTHER [Faint text]	
28. SIGNATURE OF OTHER [Faint text]		29. SIGNATURE OF OTHER [Faint text]		30. SIGNATURE OF OTHER [Faint text]	
31. SIGNATURE OF OTHER [Faint text]		32. SIGNATURE OF OTHER [Faint text]		33. SIGNATURE OF OTHER [Faint text]	
34. SIGNATURE OF OTHER [Faint text]		35. SIGNATURE OF OTHER [Faint text]		36. SIGNATURE OF OTHER [Faint text]	
37. SIGNATURE OF OTHER [Faint text]		38. SIGNATURE OF OTHER [Faint text]		39. SIGNATURE OF OTHER [Faint text]	
40. SIGNATURE OF OTHER [Faint text]		41. SIGNATURE OF OTHER [Faint text]		42. SIGNATURE OF OTHER [Faint text]	
43. SIGNATURE OF OTHER [Faint text]		44. SIGNATURE OF OTHER [Faint text]		45. SIGNATURE OF OTHER [Faint text]	
46. SIGNATURE OF OTHER [Faint text]		47. SIGNATURE OF OTHER [Faint text]		48. SIGNATURE OF OTHER [Faint text]	
49. SIGNATURE OF OTHER [Faint text]		50. SIGNATURE OF OTHER [Faint text]		51. SIGNATURE OF OTHER [Faint text]	
52. SIGNATURE OF OTHER [Faint text]		53. SIGNATURE OF OTHER [Faint text]		54. SIGNATURE OF OTHER [Faint text]	
55. SIGNATURE OF OTHER [Faint text]		56. SIGNATURE OF OTHER [Faint text]		57. SIGNATURE OF OTHER [Faint text]	
58. SIGNATURE OF OTHER [Faint text]		59. SIGNATURE OF OTHER [Faint text]		60. SIGNATURE OF OTHER [Faint text]	
61. SIGNATURE OF OTHER [Faint text]		62. SIGNATURE OF OTHER [Faint text]		63. SIGNATURE OF OTHER [Faint text]	
64. SIGNATURE OF OTHER [Faint text]		65. SIGNATURE OF OTHER [Faint text]		66. SIGNATURE OF OTHER [Faint text]	
67. SIGNATURE OF OTHER [Faint text]		68. SIGNATURE OF OTHER [Faint text]		69. SIGNATURE OF OTHER [Faint text]	
70. SIGNATURE OF OTHER [Faint text]		71. SIGNATURE OF OTHER [Faint text]		72. SIGNATURE OF OTHER [Faint text]	
73. SIGNATURE OF OTHER [Faint text]		74. SIGNATURE OF OTHER [Faint text]		75. SIGNATURE OF OTHER [Faint text]	
76. SIGNATURE OF OTHER [Faint text]		77. SIGNATURE OF OTHER [Faint text]		78. SIGNATURE OF OTHER [Faint text]	
79. SIGNATURE OF OTHER [Faint text]		80. SIGNATURE OF OTHER [Faint text]		81. SIGNATURE OF OTHER [Faint text]	
82. SIGNATURE OF OTHER [Faint text]		83. SIGNATURE OF OTHER [Faint text]		84. SIGNATURE OF OTHER [Faint text]	
85. SIGNATURE OF OTHER [Faint text]		86. SIGNATURE OF OTHER [Faint text]		87. SIGNATURE OF OTHER [Faint text]	
88. SIGNATURE OF OTHER [Faint text]		89. SIGNATURE OF OTHER [Faint text]		90. SIGNATURE OF OTHER [Faint text]	
91. SIGNATURE OF OTHER [Faint text]		92. SIGNATURE OF OTHER [Faint text]		93. SIGNATURE OF OTHER [Faint text]	
94. SIGNATURE OF OTHER [Faint text]		95. SIGNATURE OF OTHER [Faint text]		96. SIGNATURE OF OTHER [Faint text]	
97. SIGNATURE OF OTHER [Faint text]		98. SIGNATURE OF OTHER [Faint text]		99. SIGNATURE OF OTHER [Faint text]	
100. SIGNATURE OF OTHER [Faint text]		101. SIGNATURE OF OTHER [Faint text]		102. SIGNATURE OF OTHER [Faint text]	

BUREAU V. 2

MAY 28 1957

RECEIVED



# MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

04767

## MEDICAL EXAMINER'S CERTIFICATE OF DEATH

Reg. Dist. No. 21

4766

1. PLACE OF DEATH a. COUNTY <u>A.A. Co.</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If Institution: Residence before admission) a. STATE <u>MARYLAND</u> b. COUNTY <u>Q. A.</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>ANNAPOLIS</u>				c. LENGTH OF STAY IN 1b <u>CENTREVILLE</u>			
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>ANNE ARUNDEL Co. HOSPITAL</u>				d. STREET ADDRESS <u>17X2-2</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <u>Harry</u> Middle <u>Thomas</u> Last <u>Cole</u>				4. DATE OF DEATH Month <u>5</u> Day <u>13</u> Year <u>1957</u>			
5. SEX <u>M</u>		6. COLOR OR RACE <u>W</u>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>aug 12 - 1928</u>	
9. AGE (In years last birthday) <u>28</u> yrs.		IF UNDER 1 YEAR Months <u>2</u> Days <u>8</u>		IF UNDER 24 HRS. Hours <u>13</u> Min. <u>57</u>			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Lab. Co</u>				10b. KIND OF BUSINESS OR INDUSTRY <u>aug med.</u>		11. BIRTHPLACE (State or foreign country) <u>U.S.A.</u>	
13. FATHER'S NAME <u>Harry J. Cole</u>				14. MOTHER'S MAIDEN NAME <u>Chene Jurod.</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>No</u>		16. SOCIAL SECURITY NO. <u>(If yes, give war or dates of service)</u>		17. INFORMANT <u>Mr Harry Cole Centerville</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>fracture skull - some bones - fracture of lower extremities</u> <u>825X</u> DUE TO (b) <u>Crushing injury to chest.</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. DUE TO (c) _____ PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) _____ INTERVAL BETWEEN ONSET AND DEATH _____							
20a. EXTERNAL CAUSE WAS PRIMARY <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <u>Auto accident</u>			
20c. TIME OF INJURY Month, Day, Year <u>May 5/13/57</u> 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input checked="" type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <u>Highway</u>		20f. (City or town) (County) (State) <u>HACC MD</u>	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input type="checkbox"/> , Inquiry <input type="checkbox"/> , and find that death resulted from: Natural causes <input type="checkbox"/> , Accident <input checked="" type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined cause <input type="checkbox"/> .							
ACTUAL SIGNATURE <u>John Paul</u>				M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/>			
EXAMINER'S NAME (Type) <u>E. Linhardt</u>				ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>			
				DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>MAY 15</u>		22c. NAME OF CEMETERY OR CREMATORY <u>Centerville</u>		22d. LOCATION (City, town, or county) (State) <u>Centerville Md</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Edgar L. Panel</u>				ADDRESS <u>Church Hill, Md.</u>		24a. REC'D BY REGISTRAR DATE <u>5/17/57</u>	
				24b. REGISTRAR'S SIGNATURE <u>Dr. J. M. French</u>			

MEDICAL CERTIFICATION

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.

RECEIVED

MAY 17 1957

BUREAU V. S.

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

MASSACHUSETTS STATE DEPARTMENT OF HEALTH - BOSTON

1

## INSTRUCTIONS

TO ATTENDING PHYSICIAN OR HOSPITAL: The law requires that the death certificate be executed within 72 hours after death. The bottom copy shall be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: The law requires that the death certificate be filed with the registrar within 72 hours after death. After this certificate has been executed by the attending physician and completely filled in by the funeral director, the third copy of this death certificate assembly should be detached for use as a burial transit permit.

VS AISC 1-55 10M

MARYLAND STATE DEPARTMENT OF HEALTH-BALTIMORE, 18

04768

4796

## CERTIFICATE OF DEATH

Item 12 Film G216 6-17-57 et

Reg. Dist. No. ....

1. PLACE OF DEATH				2. USUAL RESIDENCE (HOME) OF DECEASED			
COUNTY <b>Anna Arundel</b>		MARYLAND		STATE <b>Md.</b>		COUNTY <b>A. A.</b>	
CITY (If outside corporate limits, write RURAL OR end give nearest town) TOWN <b>N. Linthicum</b>		LENGTH OF STAY (in this place)		CITY (If outside corporate limits, write RURAL end give nearest town) TOWN <b>N. Linthicum</b>			
HOSPITAL OR INSTITUTION OR STREET ADDRESS				STREET ADDRESS (If rural give location) <b>Hampton Road</b>			
3. NAME OF DECEASED (Type or Print)				4. DATE OF DEATH			
(First) <b>HENRY</b> (Middle) <b>F.</b> (Last) <b>COREY</b>				(Month) <b>MAY</b> (Day) <b>24</b> (Year) <b>19 57</b>			
5. SEX <b>male</b>	6. COLOR OR RACE <b>white</b>	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) <b>married</b>	8. DATE OF BIRTH <b>June 4, 1878</b>	9. AGE last birthday <b>78</b> yrs.	IF UNDER 1 YEAR Months Days		IF UNDER 24 HRS. Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>builder &amp; contractor</b>			10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) <b>England</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>
13. FATHER'S NAME <b>William Cory</b>				14. MOTHER'S MAIDEN NAME <b>Sarah Norsworthy</b>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unk.) (If Yes, give war or dates of service)			16. SOCIAL SECURITY NO.		17. INFORMANT & ADDRESS <b>Hampton Road</b> <b>Miss Constance Cory N. Linthicum</b>		
18. MEDICAL CERTIFICATION						INTERVAL BETWEEN ONSET AND DEATH	
1. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH							
331X IMMEDIATE CAUSE (A) <b>Cerebral Hemorrhage</b>						<b>2 mos.</b>	
ANTECEDENT CAUSE(S) DUE TO (B) <b>Hypertension</b>						<b>2 mos.</b>	
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST, DUE TO (C)							
11 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.							
19a. DATE OF OPERATION		19b. MAJOR FINDINGS OF OPERATION					
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)		21c. WHERE DID INJURY OCCUR? (City or town) (County) (State)		20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
21d. TIME OF INJURY (Month) (Day) (Year) (Hour) (Min.)			21e. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		21f. HOW DID INJURY OCCUR?		
22. I hereby certify that I attended the deceased from <b>May 17, 19 57</b> , to <b>May 24, 19 57</b> , that I last saw the deceased alive on <b>May 21, 19 57</b> , and that death occurred at <b>4:00 A.M.</b> from the causes and on the date stated above.							
SIGNATURE <b>C. Milton Linthicum</b>				ADDRESS (Street, city, town, state) <b>106 W. Maple Rd. Linthicum Md.</b>			
DATE <b>MAY 27 1957</b>				DATE SIGNED <b>May 13 1957</b>			
23. BURIAL, CREMATION, REMOVAL (SPECIFY) <b>Burial</b>		DATE THEREOF <b>May 27, 1957</b>		NAME OF CEMETERY OR CREMATORY <b>Baldwin Memorial</b>		LOCATION (City, town, or county) (State) <b>Severn Cross Rds. A.A. co. Md.</b>	
24. REC'D BY REGISTRAR <b>MAY 27 1957</b>		REGISTRAR'S SIGNATURE <b>Overseer</b>		25. FUNERAL DIRECTOR'S SIGNATURE <b>John O. Mitchell &amp; Sons Inc.</b>		ADDRESS <b>1900 Eutaw Pl.</b>	

[illegible]

BUREAU V. 3

MAY 27 1957

RECEIVED

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be attached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

## MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

04769

4797

## CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>Anne Arundel</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Anne Arundel</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Pasadena PFD</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Pasadena PFD (Riviera Beach) X 2</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Riviera Beach - Box 303 - Rt. 4 - Meadow and Creek Rds</u>		d. STREET ADDRESS <u>Box 303 - Rt. 4 - Meadow and Creek Rds</u>	
3. NAME OF DECEASED (Type or print) First <u>Howard</u> Middle <u>Winfield</u> Last <u>Corliss Sr.</u>		4. DATE OF DEATH Month <u>May</u> Day <u>25</u> Year <u>1957</u>	
5. SEX <u>Male</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>Feb. 2, 1885</u>
9. AGE (In years last birthday) <u>72</u> yrs.		IF UNDER 1 YEAR Months <u>  </u> Days <u>  </u> Hours <u>  </u> Min. <u>  </u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Clerk (retired)</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>General Elec. Co.</u>	
11. BIRTHPLACE (State or foreign country) <u>Virginia</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>Joseph Corliss</u>		14. MOTHER'S MAIDEN NAME <u>Eva</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>No</u>		16. SOCIAL SECURITY NO. <u>Unknown</u>	
17. INFORMANT <u>Mr. Charles U. Reininger</u>		Address <u>Same As #2</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Acute coronary thrombosis</u> <u>420.1</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <u>arteriosclerotic Cardio-vascular disease</u> DUE TO (c) <u>angina pectoris</u>		INTERVAL BETWEEN ONSET AND DEATH <u>3 hours</u> <u>10 years</u> <u>18 years</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>none</u>		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <u>19</u>		20d. INJURY OCCURRED White <input type="checkbox"/> Not white <input type="checkbox"/> of work <input type="checkbox"/> of work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>April 4, 1957</u> , to <u>May 25, 1957</u> , that I lost the deceased alive on <u>May 25, 1957</u> , and that death occurred at <u>2:30 PM</u> , from the causes and on the date stated above.			
ACTUAL SIGNATURE <u>R. M. McLaughlin</u>		ADDRESS (Street, city or town, state) <u>Mountain Road Pasadena Maryland</u>	
DATE SIGNED <u>May 25, 1957</u>			
PHYSICIAN'S NAME (Type) <u>R. M. McLaughlin</u>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>May 28, 1957</u>	
22c. NAME OF CEMETERY OR CREMATORY <u>Northwood Cem.</u>		22d. LOCATION (City, town, or county) (State) <u>Philadelphia Pennsylvania</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Richard V. Singleton</u>		ADDRESS <u>Glen Burnie, Md</u>	
24a. REC'D BY REGISTRAR <u>MAY 27 1957</u>		DATE <u>07 1957</u>	
24b. REGISTRAR'S SIGNATURE <u>L. J. Kelly</u>			



THE UNIVERSITY OF CHICAGO

AY 27 1957

MAAT

## CERTIFICATE OF DEATH

04770

21

Reg. Dist. No. ....

4767

<b>1. PLACE OF DEATH</b>		<b>2. USUAL RESIDENCE (HOME) OF DECEASED</b>	
COUNTY <u>Adm</u>	MARYLAND	STATE <u>Inde</u>	COUNTY <u>Adm</u>
CITY (If outside corporate limits, write RURAL and give nearest town) <u>Annapolis</u>	LENGTH OF STAY (in this place) <u>life</u>	CITY (If outside corporate limits, write RURAL and give nearest town) <u>Annapolis</u>	TOWN <u>10</u>
HOSPITAL OR INSTITUTION OR STREET ADDRESS		STREET ADDRESS <u>30 Eastern Ave</u>	(If rural give location)
<b>3. NAME OF DECEASED</b> (First) (Middle) (Last) <u>James Basil Crowdy</u>		<b>4. DATE OF DEATH</b> (Month) (Day) (Year) <u>May 5 1957</u>	
<b>5. SEX</b> <u>M</u>	<b>6. COLOR OR RACE</b> <u>Caucas</u>	<b>7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify)</b> <u>single</u>	<b>8. DATE OF BIRTH</b> <u>June 9 1900</u>
<b>9. AGE last birthday</b> <u>56</u> yrs.		<b>IF UNDER 1 YEAR</b> (Months) (Days) <u>11</u> <u>11</u>	
<b>10a. USUAL OCCUPATION</b> (Give kind of work done during most of working life, even if retired) <u>Supervisor</u>		<b>10b. KIND OF BUSINESS OR INDUSTRY</b> <u>Eastport</u>	
<b>11. BIRTHPLACE</b> (State or foreign country) <u>Eastport</u>		<b>12. CITIZEN OF WHAT COUNTRY?</b>	
<b>13. FATHER'S NAME</b> <u>James Crowdy</u>		<b>14. MOTHER'S MAIDEN NAME</b> <u>Isabell Crowdy</u>	
<b>15. WAS DECEASED EVER IN U. S. ARMED FORCES?</b> (Yes, no, or unk.) (If Yes, give war or dates of service)		<b>16. SOCIAL SECURITY NO.</b> <u>217-18-1608</u>	
<b>17. INFORMANT &amp; ADDRESS</b> <u>Isabell Murray Crowdy</u>			
<b>I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH</b>		<b>18. MEDICAL CERTIFICATION</b>	
<b>IMMEDIATE CAUSE (A)</b> <u>410X</u>		<u>Cardia congestive Failure</u>	
<b>ANTECEDENT CAUSE(S) DUE TO (B)</b> <u>Metab Insufficiency</u>		<u>292</u>	
<b>OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.</b>			
<b>19a. DATE OF OPERATION</b>		<b>19b. MAJOR FINDINGS OF OPERATION</b>	
<b>21a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)</b>		<b>21b. PLACE (Home, farm, factory, of INJURY street, office bldg., etc.)</b>	
<b>21c. WHERE DID INJURY OCCUR? (City or town) (County) (State)</b>			
<b>21d. TIME OF INJURY (Month) (Day) (Year) (Hour)</b>		<b>21e. INJURY OCCURRED While at work Not while at work</b>	
<b>21f. HOW DID INJURY OCCUR?</b>			
<b>22. I hereby certify that I attended the deceased from 1/22, 1957, to 5/5, 1957, that I last saw the deceased alive on 5/5, 1957, and that death occurred at 6 PM, from the causes and on the date stated above.</b>			
<b>SIGNATURE</b> <u>Hedra H. Johnson</u>		<b>ADDRESS (Street, city, town, state)</b> <u>37 Cabot Street Annapolis, Md</u>	
<b>DATE</b> <u>5/15/57</u>		<b>DATE SIGNED</b> <u>5/15/57</u>	
<b>23. BURIAL, CREMATION, REMOVAL (SPECIFY)</b> <u>MASS</u>		<b>24. NAME OF CEMETERY OR CREMATORY</b> <u>Annapolis neck</u>	
<b>25. LOCATION (City, town, or county) (State)</b> <u>Annapolis Ind</u>			
<b>26. REG'D BY REGISTRAR</b> <u>1957</u>		<b>27. REGISTRAR'S SIGNATURE</b> <u>Ann J. French</u>	
<b>28. FUNERAL DIRECTOR'S SIGNATURE</b> <u>Ann J. French</u>		<b>29. ADDRESS</b> <u>Annapolis</u>	

## INSTRUCTIONS

**1** TO ATTENDING PHYSICIAN OR HOSPITAL: The law requires that the death certificate be executed within 24 hours after death. The bottom copy may be retained by the hospital or attending physician.

**2** TO FUNERAL DIRECTOR: The law requires that the death certificate be filed with the registrar within 72 hours after death. After this certificate has been executed by the attending physician and completely filled in by the funeral director, the third copy of this death certificate assembly should be detached for use as a burial transit permit.

VS A15C 1-55 10M

# CERTIFICATE OF DEATH

1. DECEASED'S NAME (Print or Type)

2. PLACE OF BIRTH

3. SEX  
 4. AGE  
 5. DATE OF BIRTH

6. MARRIAGE

7. OCCUPATION  
 8. EDUCATION

9. CAUSE OF DEATH (Print or Type)

10. PLACE OF DEATH

11. DATE OF DEATH

12. SIGNATURE OF DECEASED

13. SIGNATURE OF WITNESS

14. SIGNATURE OF PHYSICIAN

15. SIGNATURE OF CLERK

16. SIGNATURE OF JUDGE

17. SIGNATURE OF SHERIFF

18. SIGNATURE OF CORONER

19. SIGNATURE OF JURY

20. SIGNATURE OF JUDGE

21. SIGNATURE OF SHERIFF

22. SIGNATURE OF JURY

23. SIGNATURE OF JUDGE

24. SIGNATURE OF SHERIFF

25. SIGNATURE OF JURY

26. SIGNATURE OF JUDGE

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41. SIGNATURE OF JUDGE

42. SIGNATURE OF SHERIFF

43. SIGNATURE OF JURY

44. SIGNATURE OF JUDGE

BUREAU V. S.

AY 8 1957

RECEIVED

NOTIFICATION

1. DECEASED'S NAME (Print or Type)  
 2. PLACE OF BIRTH  
 3. SEX  
 4. AGE  
 5. DATE OF BIRTH  
 6. MARRIAGE  
 7. OCCUPATION  
 8. EDUCATION  
 9. CAUSE OF DEATH (Print or Type)  
 10. PLACE OF DEATH  
 11. DATE OF DEATH  
 12. SIGNATURE OF DECEASED  
 13. SIGNATURE OF WITNESS  
 14. SIGNATURE OF PHYSICIAN  
 15. SIGNATURE OF CLERK  
 16. SIGNATURE OF JUDGE  
 17. SIGNATURE OF SHERIFF  
 18. SIGNATURE OF CORONER  
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 97. SIGNATURE OF JURY  
 98. SIGNATURE OF JUDGE  
 99. SIGNATURE OF SHERIFF  
 100. SIGNATURE OF JURY

4798

## CERTIFICATE OF DEATH

Reg. Dist. No. 28

1. PLACE OF DEATH o. COUNTY <u>A. A.</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE <u>Md.</u> b. COUNTY <u>A. A.</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Crownsville</u>				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Crownsville</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION				d. STREET ADDRESS <u>1</u>			
3. NAME OF DECEASED (Type or print) First Middle Last <u>Annanda Davis</u>				4. DATE OF DEATH Month Day Year <u>May 18 1957</u>			
5. SEX <u>Female</u>		6. COLOR OR RACE <u>Colored</u>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>June 10 1892</u>	
9. AGE (In years last birthday) <u>64</u> yrs.		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Domestic</u>		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) <u>Orangeburg S.C.</u>	
13. FATHER'S NAME <u>Leon Davis</u>				14. MOTHER'S MAIDEN NAME <u>Grace Gardner</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)				16. SOCIAL SECURITY NO.		17. INFORMANT <u>Malles S. Bridges</u> Address <u>Phila Pa.</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>CORONARY occlusion</u> <u>420.1</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <u>ARTERIOSCLEROTIC CORONARY ARTERY DISEASE</u> DUE TO (c) _____ PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) _____							INTERVAL BETWEEN ONSET AND DEATH <u>4 HOUR</u> <u>UNKNOWN</u>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. p. m. 19				20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work at work		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town) (County) (State)							
21. I certify that I attended the deceased from _____, 19____, to _____, 19____, that I last saw the deceased alive on _____, 19____, and that death occurred at <u>1:35 A.M.</u> from the causes and on the date stated above.							
ACTUAL SIGNATURE <u>Edward S. Beck</u> M.D.				ADDRESS (Street, city or town, state) <u>41 Southgate Ave.</u>		DATE SIGNED <u>5/21/57</u>	
PHYSICIAN'S NAME (Type) <u>Edward S. Beck M.D.</u>				Annapolis, Md.			
22a. BURIAL, CREMATION, REMOVAL (Specify)		22b. DATE THEREOF <u>May 23/57</u>		22c. NAME OF CEMETERY OR CREMATORY <u>BETHESDA CEMETERY</u>		22d. LOCATION (City, town, or county) (State) <u>Orangeburg S.C.</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Annal A. Starnam</u>				ADDRESS <u>Annapolis</u>		24a. REC'D BY REGISTRAR <u>5/23/57</u>	
				24b. REGISTRAR'S SIGNATURE <u>Katharine Joyce</u>			

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be attached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

BUREAU A B

1957

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RECEIVED



MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18  
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

04772

Reg. Dist. No. 24

4799

1. PLACE OF DEATH a. COUNTY <b>Anne Arundel</b> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Md.</b> b. COUNTY <b>Queen Anne</b>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Arnold</b>				c. LENGTH OF STAY IN 1b <b>Few Min.</b>			
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <b>Ritchie Highway</b>				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First <b>John</b> Middle <b>William</b> Last <b>Dawkins</b>				4. DATE OF DEATH Month <b>May</b> Day <b>13</b> Year <b>1957</b>			
5. SEX <b>M</b>		6. COLOR OR RACE <b>W</b>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <b>12/5/32</b>	
9. AGE (In years last birthday) <b>24</b> yrs.		IF UNDER 1 YEAR Months <b>24</b> Days <b>13</b>		IF UNDER 24 HRS. Hours <b>13</b> Min. <b>57</b>			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Labarer</b>				10b. KIND OF BUSINESS OR INDUSTRY <b>State Road Employee</b>			
11. BIRTHPLACE (State or foreign country) <b>Centerville Maryland</b>				12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>			
13. FATHER'S NAME <b>John J. Dawkins</b>				14. MOTHER'S MAIDEN NAME <b>Sadie Dell</b>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (If yes, no, or unknown) <b>Yes</b>				16. SOCIAL SECURITY NO. <b>21-4-30-5349</b>			
17. INFORMANT <b>John J. Dawkins</b>				Address <b>Centerville Maryland</b>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Fracture of Skull</b> 825X DUE TO Conditions, if any, which gave rise to immediate cause (b) (c) <b>825X</b> DUE TO (c) <b>825X</b>							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <b>Interval between onset and death</b> <b>Sudden</b>							
20a. EXTERNAL CAUSE WAS PRIMARY <input checked="" type="checkbox"/> OR CONTRIBUTING CAUSE OF DEATH <input type="checkbox"/>				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <b>Thrown from Car and hit a tree</b>			
20c. TIME OF INJURY Month, Day, Year <b>1:02 a.m. 5/13 1957</b>				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input checked="" type="checkbox"/>			
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <b>Rte 2, AA Co., Md.</b>				20f. (City or town) (County) (State) <b>AA Co., Md.</b>			
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and find that death resulted from: Natural causes <input type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined cause <input type="checkbox"/> .							
ACTUAL SIGNATURE <b>Gustave H. Faubert</b>				CHIEF MEDICAL EXAMINER <input type="checkbox"/>			
EXAMINER'S NAME (Type) <b>Gustave H. Faubert, M. D.</b>				ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>			
DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>				DATE SIGNED <b>May 13, 1957</b>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>				22b. DATE THEREOF <b>May 15-57</b>			
22c. NAME OF CEMETERY OR CREMATORY <b>Christfield</b>				22d. LOCATION (City, town, or county) (State) <b>Centerville Maryland</b>			
23. FUNERAL DIRECTOR'S SIGNATURE <b>Barton B. W. Burton</b>				24a. REC'D BY REGISTRAR DATE <b>5/14/57</b>			
ADDRESS <b>Centerville Maryland</b>				24b. REGISTRAR'S SIGNATURE <b>Louis J. DeAlba</b>			

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM-3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.

MARYLAND STATE DEPARTMENT OF HEALTH - BALTIMORE 18  
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

NAME OF DECEASED		AGE		SEX		RACE	
DATE OF DEATH		TIME OF DEATH		PLACE OF DEATH		CITY	
CAUSE OF DEATH		MANNER OF DEATH		DISEASE		SYMPTOMS	
SIGNATURE OF EXAMINER		DATE		TIME		PLACE	

BUREAU 11 B

MAY 16 1957

RECEIVED

4800

## CERTIFICATE OF DEATH

Reg. Dist. No.

21

1. PLACE OF DEATH a. COUNTY <u>Anne Arundel</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>C.C.</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Annapolis</u>				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Annapolis</u> x2			
d. NAME OF HOSPITAL (If not in-hospital, give street address) <u>1. F. N. 13 Carrs Beach Rd.</u>				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First Middle Last <u>Henry James Dobson</u>				4. DATE OF DEATH Month Day Year <u>5 28 1957</u>			
5. SEX <u>Male</u>		6. COLOR OR RACE <u>Col.</u>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>4-18-1884</u>	
9. AGE (In years last birthday) <u>73</u> yrs.		10a. USUAL OCCUPATION (Give kind of work done during most of working life; even if retired) <u>Retired</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Lumber Co.</u>		11. BIRTHPLACE (State or foreign country) <u>Maryland</u>	
12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>				13. FATHER'S NAME <u>Unknown</u>			
14. MOTHER'S MAIDEN NAME <u>Unknown</u>				15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>No</u>			
16. SOCIAL SECURITY NO. <u>214-05-1142</u>				17. INFORMANT Address <u>Mary E. Wells - Annapolis, Md.</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Coronary Arterio Sclerosis</u> <u>434.1</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) _____ (c) _____ DUE TO PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) _____							INTERVAL BETWEEN ONSET AND DEATH <u>24 days</u>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)							20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <u>19</u>			20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)
21. I certify that I attended the deceased from <u>5-2-57</u> , 19 <u>57</u> , to <u>5-29-57</u> , 19 <u>57</u> , that I last saw the deceased alive on <u>5-27-57</u> , 19 <u>57</u> , and that death occurred at <u>10:30</u> M, from the causes and on the date stated above. ADDRESS (Street, city or town, state) <u>62 E. ...</u> DATE SIGNED <u>5-29-57</u>							
ACTUAL SIGNATURE <u>A.T. Allen</u> M.D. <u>62 E. ...</u>							
PHYSICIAN'S NAME (Type) <u>A.T. ALLEN</u> <u>Annapolis Md</u>							
22a. BURIAL, CREMATION, REMOVAL (Specify)		22b. DATE THEREOF		22c. NAME OF CEMETERY OR CREMATORY		22d. LOCATION (City, town, or county) (State)	
<u>Burial</u>		<u>5-31-57</u>		<u>Brewer Hill</u>		<u>Annapolis, Md.</u>	
23. FUNERAL DIRECTOR'S SIGNATURE ADDRESS <u>William Reese, Jr. - Annapolis, Md.</u>				24a. REC'D BY REGISTRAR DATE <u>5/29/57</u>		24b. REGISTRAR'S SIGNATURE <u>Wm. J. French</u>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

CERTIFICATE OF DEATH

Section 11

1. NAME OF DECEASED		2. SEX		3. AGE		4. DATE OF BIRTH	
5. PLACE OF BIRTH		6. OCCUPATION		7. CAUSE OF DEATH		8. PLACE OF DEATH	
9. DATE OF DEATH		10. TIME OF DEATH		11. SIGNATURE OF PHYSICIAN		12. SIGNATURE OF REGISTRAR	
13. SIGNATURE OF WITNESS		14. SIGNATURE OF WITNESS		15. SIGNATURE OF WITNESS		16. SIGNATURE OF WITNESS	
17. SIGNATURE OF WITNESS		18. SIGNATURE OF WITNESS		19. SIGNATURE OF WITNESS		20. SIGNATURE OF WITNESS	
21. SIGNATURE OF WITNESS		22. SIGNATURE OF WITNESS		23. SIGNATURE OF WITNESS		24. SIGNATURE OF WITNESS	
25. SIGNATURE OF WITNESS		26. SIGNATURE OF WITNESS		27. SIGNATURE OF WITNESS		28. SIGNATURE OF WITNESS	
29. SIGNATURE OF WITNESS		30. SIGNATURE OF WITNESS		31. SIGNATURE OF WITNESS		32. SIGNATURE OF WITNESS	
33. SIGNATURE OF WITNESS		34. SIGNATURE OF WITNESS		35. SIGNATURE OF WITNESS		36. SIGNATURE OF WITNESS	
37. SIGNATURE OF WITNESS		38. SIGNATURE OF WITNESS		39. SIGNATURE OF WITNESS		40. SIGNATURE OF WITNESS	
41. SIGNATURE OF WITNESS		42. SIGNATURE OF WITNESS		43. SIGNATURE OF WITNESS		44. SIGNATURE OF WITNESS	
45. SIGNATURE OF WITNESS		46. SIGNATURE OF WITNESS		47. SIGNATURE OF WITNESS		48. SIGNATURE OF WITNESS	
49. SIGNATURE OF WITNESS		50. SIGNATURE OF WITNESS		51. SIGNATURE OF WITNESS		52. SIGNATURE OF WITNESS	
53. SIGNATURE OF WITNESS		54. SIGNATURE OF WITNESS		55. SIGNATURE OF WITNESS		56. SIGNATURE OF WITNESS	
57. SIGNATURE OF WITNESS		58. SIGNATURE OF WITNESS		59. SIGNATURE OF WITNESS		60. SIGNATURE OF WITNESS	
61. SIGNATURE OF WITNESS		62. SIGNATURE OF WITNESS		63. SIGNATURE OF WITNESS		64. SIGNATURE OF WITNESS	
65. SIGNATURE OF WITNESS		66. SIGNATURE OF WITNESS		67. SIGNATURE OF WITNESS		68. SIGNATURE OF WITNESS	
69. SIGNATURE OF WITNESS		70. SIGNATURE OF WITNESS		71. SIGNATURE OF WITNESS		72. SIGNATURE OF WITNESS	
73. SIGNATURE OF WITNESS		74. SIGNATURE OF WITNESS		75. SIGNATURE OF WITNESS		76. SIGNATURE OF WITNESS	
77. SIGNATURE OF WITNESS		78. SIGNATURE OF WITNESS		79. SIGNATURE OF WITNESS		80. SIGNATURE OF WITNESS	
81. SIGNATURE OF WITNESS		82. SIGNATURE OF WITNESS		83. SIGNATURE OF WITNESS		84. SIGNATURE OF WITNESS	
85. SIGNATURE OF WITNESS		86. SIGNATURE OF WITNESS		87. SIGNATURE OF WITNESS		88. SIGNATURE OF WITNESS	
89. SIGNATURE OF WITNESS		90. SIGNATURE OF WITNESS		91. SIGNATURE OF WITNESS		92. SIGNATURE OF WITNESS	
93. SIGNATURE OF WITNESS		94. SIGNATURE OF WITNESS		95. SIGNATURE OF WITNESS		96. SIGNATURE OF WITNESS	
97. SIGNATURE OF WITNESS		98. SIGNATURE OF WITNESS		99. SIGNATURE OF WITNESS		100. SIGNATURE OF WITNESS	

BUREAU V. 8

MAY 31 1957

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TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.

VS. A15ME(S)  
5M 9/55

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

04775

Reg. Dist. No.

\*File G218 7/24/57 4801

1. PLACE OF DEATH a. COUNTY Anne Arundel MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Same Md. b. COUNTY A.A.	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Pasadena		c. LENGTH OF STAY IN 1b 9 years.	
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) X2 Same Pasadena		d. STREET ADDRESS 1 Same Mill Rd. Route 9 Box 89	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Mill Road Route 9 Box 89		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Middle Last John Doyle		4. DATE OF DEATH Month Day Year May the 25th. 19 57	
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 9/25/1905
9. AGE (In years last birthday) 51 yrs.		10. IF UNDER 1 YEAR Months Days Hours Min.	11. IF UNDER 24 HRS.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Machinist at the U.S.A. Coast Guard.		11. BIRTHPLACE (State or foreign country) Christianburg, Va.	
12. CITIZEN OF WHAT COUNTRY?			
13. FATHER'S NAME Walter B. Doyle		14. MOTHER'S MAIDEN NAME Rosetta E.	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO.	
17. INFORMANT Mr. R.J. Sarber		Address Route 2 Roanoke, Va.	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 490X Lobar Pneumonia Rt Lower lobe DUE TO (b) Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. DUE TO (c)		INTERVAL BETWEEN ONSET AND DEATH	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)		19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> Inspection <input type="checkbox"/> Inquiry <input type="checkbox"/> and find that death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined cause <input type="checkbox"/> .			
ACTUAL SIGNATURE EXAMINER'S NAME (Type) Wm. J. Beckner		M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input checked="" type="checkbox"/> DEPUTY MEDICAL EXAMINER <input type="checkbox"/>	
DATE SIGNED 5-26-57			
22a. BURIAL, CREMATION, REMOVAL (Specify) Removal		22b. DATE THEREOF 5/26/57	
22c. NAME OF CEMETERY OR CREMATORY Wm. J. Beckner Sons Mch. Balto 17, Md		22d. LOCATION (City, town, or county) (State) Roanoke, Va.	
23. FUNERAL DIRECTOR'S SIGNATURE Wm. J. Beckner Sons Mch. Balto 17, Md		24a. REC'D BY REGISTRAR DATE 5/27/57	
24b. REGISTRAR'S SIGNATURE L. J. Sealby			

MEDICAL CERTIFICATION



note: film 218 7/24: Applicant's letter 7/24 under Doyle: Comes.  
Divorce Decree 3/55 Roubava - confirmed  
from 1942 Application. L 7/24/57

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MAY 28 1957

BUREAU V. 1

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

## MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

4768

## CERTIFICATE OF DEATH

04776

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>Anne Arundel</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE <u>Maryland</u> b. COUNTY <u>W.C.</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Annapolis</u>		c. LENGTH OF STAY IN 1b	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>1170 Bery Ct.</u>		d. STREET ADDRESS <u>1170 Bery Ct.</u>	
3. NAME OF DECEASED (Type or print) <u>Esquividor Escumbise</u>		4. DATE OF DEATH <u>5</u> Month <u>13</u> Day <u>19</u> Year <u>57</u>	
5. SEX <u>male</u>	6. COLOR OR RACE <u>Cal.</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>9-18-1896</u>
9. AGE (In years last birthday) <u>60</u> yrs.		IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Retired</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>U.S. Navy</u>	
11. BIRTH PLACE (State or foreign country) <u>Philippine Is.</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>Circadio Escumbise</u>		14. MOTHER'S MAIDEN NAME <u>Unknown</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>yes</u> <u>WWI+II</u>		16. SOCIAL SECURITY NO. <u>—</u>	
17. INFORMANT <u>Katherine Escumbise</u>		Address <u>Anna. Md.</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c.)] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Coronary Thrombosis</u> <u>420.0</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Coronary Artery Disease</u> (c) <u>Arterio-sclerotic Hypertensive disease</u>		INTERVAL BETWEEN ONSET AND DEATH	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <u>19</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>April 29</u> , 19 <u>56</u> , to <u>May 13</u> , 19 <u>57</u> , that I last saw the deceased alive on <u>May 13</u> , 19 <u>57</u> , and that death occurred at <u>1:30 PM</u> , from the causes and on the date stated above.			
ACTUAL SIGNATURE <u>R. A. Richardson</u>		M.D. <u>110 - CLAY ST ANNAPOLIS</u>	
PHYSICIAN'S NAME (Type) <u>R. A. Richardson</u>		DATE SIGNED <u>5/13/57</u>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>5-16-57</u>	
22c. NAME OF CEMETERY OR CREMATORY <u>Anna. Natl</u>		22d. LOCATION (City, town, or county) (State) <u>Annapolis Md.</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>William Geese</u>		ADDRESS <u>W - Anna. Md.</u>	
24a. REC'D BY REGISTRAR <u>DATE 5/14/57</u>		24b. REGISTRAR'S SIGNATURE <u>Dr. Wm J. French</u>	

CERTIFICATE OF DEATH

Form with multiple sections for recording death information, including fields for name, date, cause of death, and registrar details. The form is mostly blank with some faint markings.

ORIGINAL FILED IN

BUREAU V. 4

APR 24 1957

RECEIVED

04777

## MARYLAND STATE DEPARTMENT OF HEALTH

4802 CERTIFICATE OF DEATH  
FOR MEDICAL EXAMINERS

Reg. Dist. No. 24

1. PLACE OF DEATH: COUNTY <u>Beechwood Park</u> MARYLAND		2. USUAL RESIDENCE (HOME) OF DECEASED: STATE <u>md</u> COUNTY	
CITY (If outside corporate limits, write RURAL and give nearest town) <u>magothy River</u>		CITY (If outside corporate limits, write RURAL and give nearest town) <u>Balto</u>	
HOSPITAL OR INSTITUTION OR STREET ADDRESS		STREET ADDRESS (If rural, give location) <u>1344 Woodysen st</u>	
3. NAME OF DECEASED (Type or Print)	(First) <u>John</u> (Middle) <u>Roland</u> (Last) <u>Handy</u>	4. DATE OF DEATH	(Month) <u>may</u> (Day) <u>30</u> (Year) <u>1957</u>
5. SEX <u>m</u>	6. COLOR OR RACE <u>c</u>	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) <u>m</u>	8. DATE OF BIRTH <u>July 9 1931</u>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Candy maker</u>		10b. KIND OF BUSINESS OR INDUSTRY	9. AGE last birthday <u>25</u> yrs.
11. BIRTHPLACE (State or foreign country) <u>md</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>William Handy</u>		14. MOTHER'S MAIDEN NAME <u>Ellen Lee</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES (Yes, no, or unknown) (If yes, give war or dates of service) <u>no</u>		16. SOCIAL SECURITY NO. <u>?</u>	
17. INFORMANT AND ADDRESS <u>Ellen Handy 1344 Woodysen st</u>		18. MEDICAL CERTIFICATION	
1. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH			INTERVAL BETWEEN ONSET AND DEATH
Immediate cause (a) <u>Accidental death by drowning</u>			<u>5 min</u>
Antecedent cause(s) (b) Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last			
(c)			
11. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death.			
19a. DATE OF OPERATION		19b. MAJOR FINDINGS OF OPERATION	
20. AUTOPSY? Yes <input type="checkbox"/> No <input type="checkbox"/>			
21. EXTERNAL CAUSE WAS PRIMARY <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		PLACE (Home, farm, factory, street, OF office bldg., etc.) INJURY <u>Beechwood Park A.A. Md.</u>	
TIME (Month) (Day) (Year) (Hour) OF INJURY <u>May 30 57 7:30 pm</u>		HOW DID INJURY OCCUR? <u>Swimming, sank and drowned</u>	
22. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> thereon and from the evidence obtained by said Autopsy, Inspection or Inquiry, find that said deceased died on the day stated above, and death in my opinion resulted from: natural causes <input type="checkbox"/> , accident <input checked="" type="checkbox"/> , suicide <input type="checkbox"/> , homicide <input type="checkbox"/> , undetermined <input type="checkbox"/> .			
SIGNATURE <u>R. M. McLaughlin</u>		DATE SIGNED <u>May 30, 1957</u>	
23. BURIAL, CREMATION OR REMOVAL (Specify)		NAME OF CEMETERY OR CREMATORY	
DATE THEREOF <u>6-4-57</u>		<u>Arbutus</u>	
24. FUNERAL DIRECTOR		ADDRESS	
<u>L. J. Adkins</u>		<u>1348 N. Calhoun st</u>	

MARGIN RESERVED FOR BINDING

PLEASE WRITE MAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct is especially important. Physicians: please write the causes of death clearly and legibly.

RECEIVED

JUN 4 1957

BUREAU V. S.

John Roland Handy  
1344 Woodyear St  
Baltimore Md age 25



TO BE RETAINED BY THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

# MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

4803

## CERTIFICATE OF DEATH

04778

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>Anne Arundel</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution, residence before admission) o. STATE <u>Maryland</u> b. COUNTY <u>A.C.</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Drewery</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>x2 Drewery</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Route 4</u>		d. STREET ADDRESS <u>Route 4</u>	
3. NAME OF DECEASED (Type or print) First Middle Last <u>Magelie M. Harper</u>		4. DATE OF DEATH Month Day Year <u>5 5 1957</u>	
5. SEX <u>Female</u>	6. COLOR OR RACE <u>Col.</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>5-19-1919</u>
9. AGE (In years, months, days) <u>37</u> yrs.		10. IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>—</u>	
11. BIRTHPLACE (State or foreign country) <u>Maryland</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>Ciaron Johnson</u>		14. MOTHER'S MAIDEN NAME <u>Louise Chase</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, No or unknown) <u>No</u> (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. <u>—</u>	
17. INFORMANT <u>Walter Harper</u> Address <u>St. 4 - Drewery Md.</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Pulmonary edema</u> 782.4 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <u>acute myocardial failure</u> DUE TO (c) <u>—</u>			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>—</u>			
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. p. m. <u>19</u>	20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> of work <input type="checkbox"/> of work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I attended the deceased from <u>not at all</u> , to <u>12:30 P.M.</u> , that I last saw the deceased alive on <u>5-7-57</u> , and that death occurred at <u>12:30 P.M.</u> , from the causes and on the date stated above.			
ACTUAL SIGNATURE <u>Dr. H. A. Nelson</u> M.D. <u>Lothian, Md.</u>		ADDRESS (Street, city or town, state) DATE SIGNED <u>5-7-57</u>	
PHYSICIAN'S NAME (Type) <u>acting coroner</u>			
22. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>	22b. DATE THEREOF <u>5-8-57</u>	22c. NAME OF CEMETERY OR CREMATORY <u>Moses</u>	22d. LOCATION (City, town, or county) (State) <u>Drewery Md.</u>
23. FUNERAL DIRECTOR'S SIGNATURE <u>William Reese Jr.</u> ADDRESS <u>Annapolis, Md.</u>		24a. REC'D BY REGISTRAR DATE <u>MAY 10 '57</u>	24b. REGISTRAR'S SIGNATURE <u>W. H. Leach</u>

**BUREAU**

MAY 10 1957

RECEIVED

1

## MARYLAND STATE DEPARTMENT OF HEALTH-BALTIMORE, 18

## CERTIFICATE OF DEATH

04779

4769

Reg. Dist. No. 21

1. PLACE OF DEATH				2. USUAL RESIDENCE (HOME) OF DECEASED			
COUNTY <i>St. Anne</i>		MARYLAND		STATE <i>Md</i>		COUNTY <i>St. Anne</i>	
CITY (If outside corporate limits, write RURAL OR end give nearest town)		LENGTH OF STAY (in this place)		CITY (If outside corporate limits, write RURAL and give nearest town)			
TOWN <i>Annapolis</i>				TOWN <i>Annapolis</i>			
HOSPITAL OR INSTITUTION OR STREET ADDRESS				STREET ADDRESS (If rural give location)			
3. NAME OF DECEASED (Type or Print)				4. DATE OF DEATH			
<i>Lula Louise Harris</i> (First) (Middle) (Last)				<i>May 17 1957</i> (Month) (Day) (Year)			
5. SEX	6. COLOR OR RACE	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify)	8. DATE OF BIRTH	9. AGE last birthday	IF UNDER 1 YEAR		IF UNDER 24 HRS.
<i>Female</i>	<i>Colored</i>	<i>Widow</i>	<i>Nov 8 1884</i>	<i>72</i> yrs.	<i>0</i> Months	<i>0</i> Days	<i>0</i> Hours <i>0</i> Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country)		12. CITIZEN OF WHAT COUNTRY?	
<i>Domestic</i>				<i>New York City</i>		<i>U.S.A.</i>	
13. FATHER'S NAME				14. MOTHER'S MAIDEN NAME			
<i>Benjamin Brown</i>				<i>Unknown</i>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unk.)		16. SOCIAL SECURITY NO.		17. INFORMANT'S ADDRESS			
				<i>Ms Loual Rhodes</i>			
18. MEDICAL CERTIFICATION				INTERVAL BETWEEN ONSET AND DEATH			
I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH							
4413X IMMEDIATE CAUSE (A) <i>Acute Infective Hypertension</i>							
ANTECEDENT CAUSE(S) DUE TO (B) <i>Cardiovascular disease</i>				<i>2 yrs.</i>			
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST. DUE TO (C)							
11 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.							
19a. DATE OF OPERATION		19b. MAJOR FINDINGS OF OPERATION		20. AUTOPSY?			
				YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)		21c. WHERE DID INJURY OCCUR? (City or town) (County) (State)			
21d. TIME OF INJURY (Month) (Day) (Year) (Hour) (Min.)		21e. INJURY OCCURRED While <input type="checkbox"/> at work Not while <input type="checkbox"/> at work		21f. HOW DID INJURY OCCUR?			
22. I hereby certify that I attended the deceased from <i>May 17 1957</i> , to <i>May 17 1957</i> , that I last saw the deceased alive on <i>May 17 1957</i> , and that death occurred at <i>3:30 P.M.</i> from the causes and on the date stated above.							
SIGNATURE <i>J. L. Rhoades</i>				DATE SIGNED <i>May 20 1957</i>			
M.D. <i>110-CLAY ST ANNAPOLIS MD</i>							
23. BURIAL, CREMATION REMOVAL (SPECIFY)		DATE THEREOF		NAME OF CEMETERY OR CREMATORY		LOCATION (City, town, or county) (State)	
<i>Buried</i>		<i>May 21/57</i>		<i>Annapolis</i>		<i>St. Anne Co</i>	
24. REC'D BY REGISTRAR		REGISTRAR'S SIGNATURE		25. FUNERAL DIRECTOR'S SIGNATURE		ADDRESS	
DATE <i>5/23/57</i>		<i>Dr. Wm. J. French</i>		<i>Amel A. Johnson</i>		<i>Annapolis</i>	

## INSTRUCTIONS

TO ATTENDING PHYSICIAN OR HOSPITAL: The law requires that the death certificate be executed within 24 hours after death.

The bottom copy of this certificate is to be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: The law requires that the death certificate be filed with the registrar within 72 hours after death. After this certificate has been executed by the attending physician and completely filled in by the funeral director, the third copy of this death certificate assembly should be detached for use as a burial transit permit.

VS AISC 1-55 10M

# CERTIFICATE OF DEATH

Form No. 10-57

1. NAME OF DECEASED (Print or Write)

2. SEX

3. AGE

4. DATE OF BIRTH

5. PLACE OF BIRTH

6. OCCUPATION

7. CAUSE OF DEATH

8. PLACE OF DEATH

9. TIME OF DEATH

10. SIGNATURE OF PHYSICIAN

11. SIGNATURE OF REGISTRAR

12. SIGNATURE OF WITNESSES

13. SIGNATURE OF DECEASED

14. SIGNATURE OF NEXT OF KIN

15. SIGNATURE OF BURIAL OFFICIAL

16. SIGNATURE OF CHURCH OFFICIAL

17. SIGNATURE OF MINISTER

18. SIGNATURE OF CLERGYMAN

19. SIGNATURE OF RABBI

20. SIGNATURE OF OTHER

21. SIGNATURE OF OTHER

22. SIGNATURE OF OTHER

23. SIGNATURE OF OTHER

24. SIGNATURE OF OTHER

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BUREAU V. 4

1957

RECEIVED

NOTIFICATION

1. NAME OF DECEASED (Print or Write)  
2. SEX  
3. AGE  
4. DATE OF BIRTH  
5. PLACE OF BIRTH  
6. OCCUPATION  
7. CAUSE OF DEATH  
8. PLACE OF DEATH  
9. TIME OF DEATH  
10. SIGNATURE OF PHYSICIAN  
11. SIGNATURE OF REGISTRAR  
12. SIGNATURE OF WITNESSES  
13. SIGNATURE OF DECEASED  
14. SIGNATURE OF NEXT OF KIN  
15. SIGNATURE OF BURIAL OFFICIAL  
16. SIGNATURE OF CHURCH OFFICIAL  
17. SIGNATURE OF MINISTER  
18. SIGNATURE OF CLERGYMAN  
19. SIGNATURE OF RABBI  
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50. SIGNATURE OF OTHER

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

## MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

04780

4770

## CERTIFICATE OF DEATH

Reg. Dist. No.

21

1. PLACE OF DEATH a. COUNTY <u>Anne Arundel</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Anne Arundel</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Annapolis</u>				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Bay Ridge</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) <u>Anne Arundel County Hospital</u>				d. STREET ADDRESS <u>#60 River Drive</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Middle Last <u>Ben C. Hartig</u>				4. DATE OF DEATH Month Day Year <u>May 1 1957</u>			
5. SEX <u>male</u>		6. COLOR OR RACE <u>white</u>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>8/17/92</u>	
9. AGE (In years last birthday) <u>64</u> yrs.		IF UNDER 1 YEAR Months Days Hours Min.		IF UNDER 24 HRS.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Retired parking enterprise</u>				10b. KIND OF BUSINESS OR INDUSTRY <u>Washington, D.C.</u>		11. BIRTHPLACE (State or foreign country) <u>Washington, D.C.</u>	
12. CITIZEN OF WHAT COUNTRY? <u>Washington, D.C.</u>							
13. FATHER'S NAME <u>Louis Hartig, Sr.</u>				14. MOTHER'S MAIDEN NAME <u>Emma Conradis</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)				16. SOCIAL SECURITY NO.		17. INFORMANT Address <u>Ben C. Hartig, Jr. 4309 Chestnut St. Bethesda, Md.</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>massive hemorrhage of esophageal varices.</u> 581.0 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>cirrhosis of liver.</u> DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town)				20g. (County)		20h. (State)	
21. I certify that I attended the deceased from <u>June</u> , 19 <u>54</u> , to <u>May 1</u> , 19 <u>57</u> , that I last saw the deceased alive on <u>May 1</u> , 19 <u>57</u> , and that death occurred at <u>1:35 P.M.</u> from the causes and on the date stated above. ADDRESS (Street, city or town, state) DATE SIGNED <u>Amos G. Borsuck</u> <u>57.107</u> ACTUAL SIGNATURE M.D. <u>Amos G. Borsuck</u> PHYSICIAN'S NAME (Type) <u>S. Borsuck</u> <u>Annapolis Md</u>							
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>5/1/57</u>		22c. NAME OF CEMETERY OR CREMATORY <u>Rock Creek Cemetery</u>		22d. LOCATION (City, town, or county) (State) <u>Washington, D. C.</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>H. Hines Co.</u>				ADDRESS <u>2901 14th NW, D.C.</u>		24a. REC'D BY REGISTRAR <u>May 3 1957</u>	
				24b. REGISTRAR'S SIGNATURE <u>Am. J. French</u>			



BUREAU V. S.

MAY 3 1957

RECEIVED

# MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

## MEDICAL EXAMINER'S CERTIFICATE OF DEATH

04781

Reg. Dist. No. 25

4804

1. PLACE OF DEATH a. COUNTY <b>Anne Arundel</b> b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Baltimore 25</b> c. LENGTH OF STAY IN 1b <b>Few minutes</b>			2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>A.A.</b> c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Baltimore 25</b> <b>X2</b>		
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <b>Body of water in a Gravel Pitt, off Shehan- doah Ave. Baltimore 25, Md.</b>			d. STREET ADDRESS <b>136 Bishop Ave. Baltimore 25, Md.</b>		
3. NAME OF DECEASED (Type or print) <b>Willie Lee Haskett</b>			4. DATE OF DEATH Month <b>May</b> Day <b>26th.</b> Year <b>1957</b> <b>19</b>		
5. SEX <b>M.</b>	6. COLOR OR RACE <b>Colored</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>1/10/46</b>		9. AGE (In years last birthday) <b>11 yrs.</b>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Attending scholl</b>		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) <b>Baltimore, Md.</b>	12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>
13. FATHER'S NAME <b>Willie P. Haskett</b>			14. MOTHER'S MAIDEN NAME <b>Mae H. Royster</b>		
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>No</b>		16. SOCIAL SECURITY NO. <b>No</b>		17. INFORMANT <b>Willie P. Haskett (father)</b>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Accidental drowning</b> <b>929.8</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) _____ (c) _____ PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) _____ INTERVAL BETWEEN ONSET AND DEATH <b>Sudden</b>					19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <b>Attempted to swim but failed to do so.</b>			
20c. TIME OF INJURY Month, Day, Year <b>5/26/57</b> <b>19</b>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input checked="" type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <b>Water in Gravel Pitt, Baltimore 25, A.A. Md.</b>	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and find that death resulted from: Natural causes <input type="checkbox"/> , Accident <input checked="" type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined cause <input type="checkbox"/> .					
ACTUAL SIGNATURE <b>Gustave H. Faubert</b>			CHIEF MEDICAL EXAMINER <input type="checkbox"/>		
EXAMINER'S NAME (Type) <b>Gustave H. Faubert, M.D.</b>			ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>		
			DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/> <b>5/26/57</b>		
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		22b. DATE THEREOF <b>May 30, 1957</b>		22c. NAME OF CEMETERY OR CREMATORY <b>Mount Auburn Cemetery</b>	
				22d. LOCATION (City, town, or county) (State) <b>Baltimore Maryland</b>	
23. FUNERAL DIRECTOR'S SIGNATURE <b>Edw. C. Carlson</b>			24a. REC'D BY REGISTRAR <b>MAY 31 1957</b>		
			24b. REGISTRAR'S SIGNATURE <b>Ida Hutton</b>		

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM-3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.

MARYLAND STATE DEPARTMENT OF HEALTH - BALTIMORE 18  
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

BUREAU V. 5

MAY 31 1957

RECEIVED

## 4805 CERTIFICATE OF DEATH

04782 24  
Reg. Dist. No. ....

## 1. PLACE OF DEATH:

COUNTY Anne Arundel MARYLAND  
CITY (If outside corporate limits, write RURAL OR and give nearest town) Millersville  
HOSPITAL OR INSTITUTION OR STREET ADDRESS Sann's Nursing Home

## 2. USUAL RESIDENCE (HOME) OF DECEASED:

STATE Maryland COUNTY P.A.C.  
CITY (If outside corporate limits, write RURAL and give nearest town) Box 407 - Rt 9 - Ritchie Highway  
OR TOWN Pasadena R.F.D.  
STREET ADDRESS (If rural give location) Box 407 - Rt 9 - Ritchie Highway

## 3. NAME OF DECEASED:

(First) Antonia (Middle) Heisner (Last) Heisner

4. DATE OF DEATH: (Month) May (Day) 15 (Year) 1957

## 5. SEX:

Female

## 6. COLOR OR RACE:

White

## 7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify)

Widowed

## 8. DATE OF BIRTH:

April 14, 1924

9. AGE last birthday: 83 yrs. Months 15 Days 19 Hours 57 Min.

## 10a. USUAL OCCUPATION. Give kind of work done during most of working life, even if retired:

House work (ret)

## 10b. KIND OF BUSINESS OR INDUSTRY:

Own-Home

## 11. BIRTHPLACE (State or foreign country):

Baltimore Md.

## 12. CITIZEN OF WHAT COUNTRY?

U.S.A.

## 13. FATHER'S NAME:

Charles Kaiser

## 14. MOTHER'S MAIDEN NAME:

Mary Tighe

## 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.) (If Yes, give war or dates of service)

No

## 16. SOCIAL SECURITY No.:

None

## 17. INFORMANT &amp; ADDRESS:

Box 17 - Lt. Ma. Co.

## 18. MEDICAL CERTIFICATION

## 1. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH

420.0  
Immediate cause

(a)

Congestive Heart Failure

DUE TO

## Antecedent causes (s)

Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last.

(b)

Arterio sclerotic Heart Disease

DUE TO

(c)

Interval Between Onset and Death

3 M/O

4 years

## 11. OTHER SIGNIFICANT CONDITIONS

Conditions contributing to the death but not related to the disease or condition causing death.

434.1

## 19a. DATE OF OPERATION:

## 19b. MAJOR FINDINGS OF OPERATION

## 20. AUTOPSY ?

Yes ☐ No ☐

## 21. ACCIDENT SUICIDE HOMICIDE (Specify)

PLACE (Home, farm, factory, street, office bldg., etc.)

(CITY OR TOWN)

(COUNTY)

(STATE)

TIME (Month) (Day) (Year) (Hour) OF INJURY

INJURY OCCURRED While at Work ☐ Not While At Work ☐

HOW DID INJURY OCCUR ?

22. I hereby certify that I attended the deceased from Mar 22, 1957, to May 15, 1957, that I last saw the deceased

alive on May 13, 1957, and that death occurred at 11:45 PM from the causes and on the date stated above.

SIGNATURE

(Degree or title)

ADDRESS

DATE SIGNED

Edward G. Bennett M.D.

Campbell

5-17-57

## 23. BURIAL, CREMATION, REMOVAL (Specify)

## DATE THEREOF

## NAME OF CEMETERY OR CREMATORY

## LOCATION (City, town, or county)

## (State)

Burial

May 20-1957

Holy Cross Cemetery Brooklym, R.F.D.

Md.

DATE REC'D BY LOCAL REGISTRAR

REGISTRAR'S SIGNATURE

24. FUNERAL DIRECTOR

ADDRESS

May 18, 1957

L. J. DeAlba

R. S. Singleton, Gen. Burial

MARGIN RESERVED FOR BINDING

PLEASE WRITE MAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

RECEIVED

MAY 21 1957

BUREAU V. S.



4771

## CERTIFICATE OF DEATH

04783

Reg. Dist. No. 21

1. PLACE OF DEATH a. COUNTY <u>St. Anne</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Md.</u> b. COUNTY <u>St. Anne</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Annapolis</u>				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>10 Annapolis</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>A.A. Gen. Hospital</u>				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>			
3. NAME OF DECEASED (Type or print) <u>Charles J. Isaac</u> First Middle Last		4. DATE OF DEATH <u>May 12</u> Month Day Year		5. SEX <u>Male</u>		6. COLOR OR RACE <u>Caucasian</u>	
7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>July 28 1901</u>		9. AGE (In years last birthday) <u>55</u> Yes <input type="checkbox"/> No <input type="checkbox"/>		10. UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Architectural Draftman</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Boyle, Md.</u>		11. BIRTH PLACE (State or foreign country) <u>U.S.A.</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>Charles Henry</u>				14. MOTHER'S MAIDEN NAME <u>Clarence</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>No</u>		16. SOCIAL SECURITY NO. <u>04-111111</u>		17. INFORMANT <u>Charles Henry</u> Address <u>Annapolis</u>		INTERVAL BETWEEN ONSET AND DEATH <u>5 hrs</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Cerebral Hemorrhage</u> <u>443X</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Arterial Hypertensive Cardiovascular Disease</u> DUE TO (c) <u>Ischemic</u> PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>331X</u>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <u>19</u>		20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>5/12/57</u> to <u>5/14/57</u> , that I last saw the deceased alive on <u>5/12/57</u> , and that death occurred at <u>10:15 PM</u> , from the causes and on the date stated above.							
ACTUAL SIGNATURE <u>R. P. Richardson</u> M.D.				DATE SIGNED <u>5/14/57</u>			
PHYSICIAN'S NAME (Type) <u>Richardson</u>				ADDRESS (Street, city or town, state) <u>110-2145 ST. ANNAPOLIS, MD.</u>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>5/15/57</u>		22c. NAME OF CEMETERY OR CREMATORY <u>St. Mary's</u>		22d. LOCATION (City, town, or county) (State) <u>Annapolis Md</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Ann H. Johnson</u> ADDRESS <u>Annapolis</u>				24a. REC'D BY REGISTRAR <u>Dr. Wm. Prunch</u>		24b. REGISTRAR'S SIGNATURE <u>Dr. Wm. Prunch</u>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

CERTIFICATE OF DEATH

BUREAU V. 2

MAY 17 1957

RECEIVED

4772

## CERTIFICATE OF DEATH

Reg. Dist. No. 27

1. PLACE OF DEATH a. COUNTY <u>Anne Arundel</u> <u>MARYLAND</u>		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Anne Arundel</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Annapolis</u>		c. LENGTH OF STAY IN 1b <u>15 days</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Anne Arundel General Hosp.,</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <u>Floyd Jesse Hensley</u>		4. DATE OF DEATH <u>May 15 1957</u>	
5. SEX <u>Male</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>Aug 31/12</u>
9. AGE (In years last birthday) <u>44</u>		10. IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Section Man</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Nat'l. Plastic</u>	
11. BIRTHPLACE (State or foreign country) <u>North Carolina</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>Frank Hensley</u>		14. MOTHER'S MAIDEN NAME <u>Lillie Holman</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>no</u>		16. SOCIAL SECURITY NO. <u>240-22-7380</u>	
17. INFORMANT <u>Mrs. Nancy Hensley, Same As #2</u>		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>diffuse peritonitis &amp; disorder of</u> <u>587.0</u> DUE TO <u>obstruction</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>anti peritonitis.</u> DUE TO (c) <u>anti peritonitis.</u>		INTERVAL BETWEEN ONSET AND DEATH <u>10 days</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>576x</u>		19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. p. m. <u>19</u>		20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> of work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>Apr 1</u> , 19 <u>57</u> , to <u>May 15</u> , 19 <u>57</u> , that I last saw the deceased alive on <u>5/15</u> , 19 <u>57</u> , and that death occurred at <u>6:25</u> M., from the causes and on the date stated above.			
ACTUAL SIGNATURE <u>S. Borrsuck</u> M.D. <u>Amos G. Burnie</u>		DATE SIGNED <u>5/15/57</u>	
PHYSICIAN'S NAME (Type) <u>S. Borrsuck, M.D.</u>		<u>Annapolis, Md</u>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>May 18, 1957</u>	
22c. NAME OF CEMETERY OR CREMATORY <u>Glen Haven Cemetery</u>		22d. LOCATION (City, town, or county) (State) <u>Glen Burnie, Maryland</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Richard J. Langley</u> ADDRESS <u>Glen Burnie, Md.</u>		24a. REC'D BY REGISTRAR <u>Dr. Wm. P. Prunty</u>	
24b. REGISTRAR'S SIGNATURE		DATE <u>5/17/57</u>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 1 may be retained by the hospital or attending physician. After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

CERTIFICATE OF DEATH

NAME OF DECEASED		SEX		AGE		DATE OF BIRTH	
JAMES H. HARRIS		Male		45		1912	
PLACE OF BIRTH		MARRIAGE		DATE OF DEATH		PLACE OF DEATH	
Baltimore, Md.		Married		May 17, 1957		Baltimore, Md.	
CAUSE OF DEATH		MANNER OF DEATH		DATE OF INTERMENT		PLACE OF INTERMENT	
Heart Disease		Natural		May 17, 1957		Baltimore, Md.	
SIGNATURE OF PHYSICIAN		SIGNATURE OF REGISTRAR		DATE		PLACE	
J. H. Harris		J. H. Harris		May 17, 1957		Baltimore, Md.	

BUREAU V. 1

MAY 17 1957

RECEIVED

TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

## MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

04785

4773

## CERTIFICATE OF DEATH

Reg. Dist. No. 21

1. PLACE OF DEATH a. COUNTY <b>Anne Arundel</b> <b>MARYLAND</b>		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Anne Arundel</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Annapolis</b>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>10 Annapolis</b>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>Anne Arundel General Hospital</b>		d. STREET ADDRESS <b>111 Charles Street</b>	
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First <b>Baby</b> Middle <b>Boy</b> Last <b>Higgs</b>		4. DATE OF DEATH Month <b>May</b> Day <b>20</b> , Year <b>1957</b>	
5. SEX <b>Male</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>May 9, 1957</b>
9. AGE (In years last birthday) yrs. <b>—</b>		IF UNDER 1 YEAR Months <b>—</b> Days <b>11</b>	IF UNDER 24 HRS. Hours <b>—</b> Min. <b>—</b>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>None</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>none</b>	11. BIRTHPLACE (State or foreign country) <b>Annapolis, Md.</b>
12. CITIZEN OF WHAT COUNTRY? <b>USA</b>			
13. FATHER'S NAME <b>Wayne W. Higgs</b>		14. MOTHER'S MAIDEN NAME <b>Lucy G. Chubb</b>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. <b>—</b>	
17. INFORMANT <b>Wayne W. Higgs - Father - Same as # 2</b>		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>776X</b> DUE TO <b>Pharyngitis</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <b>—</b> DUE TO <b>—</b> (c) <b>—</b> PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <b>—</b> INTERVAL BETWEEN ONSET AND DEATH <b>8 hrs</b>			
19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. <b>19</b> p. m. <b>—</b>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <b>—</b>
20f. (City or town) <b>—</b>		(County) <b>—</b> (State) <b>—</b>	
21. I certify that I attended the deceased from <b>5/9</b> , 19 <b>57</b> , to <b>5/20</b> , 19 <b>57</b> , that I last saw the deceased alive on <b>5/20</b> , 19 <b>57</b> , and that death occurred at <b>12:30</b> M., from the causes and on the date stated above. ADDRESS (Street, city or town, state) <b>95 Calverton St - Annapolis, Md</b> DATE SIGNED <b>5/20/57</b> ACTUAL SIGNATURE <b>Philip Briscoe</b> M.D. PHYSICIAN'S NAME (Type) <b>Philip Briscoe MD</b>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		22b. DATE THEREOF <b>May 24, 1957</b>	22c. NAME OF CEMETERY OR CREMATORY <b>National Cemetery</b>
22d. LOCATION (City, town, or county) <b>Annapolis, Md.</b>		(State) <b>—</b>	
23. FUNERAL DIRECTOR'S SIGNATURE <b>Hopping Funeral Home</b>		ADDRESS <b>Annapolis, Md.</b>	
24a. REC'D BY REGISTRAR <b>5/24/57</b>		24b. REGISTRAR'S SIGNATURE <b>—</b>	



CERTIFICATE OF DEATH

NAME OF DECEASED		SEX		AGE		DATE OF BIRTH	
JAMES H. HARRIS		Male		65		1890	
PLACE OF BIRTH		RACE		OCCUPATION		EDUCATION	
Baltimore, Md.		White		Carpenter		High School	
MARITAL STATUS		RELIGION		CAUSE OF DEATH		MANNER OF DEATH	
Married		Roman Catholic		Heart Disease		Natural	
DATE OF DEATH		PLACE OF DEATH		HOURS OF DEATH		TEMPERATURE	
May 27, 1957		Home		10:00 AM		Normal	
SIGNATURE OF PHYSICIAN		SIGNATURE OF REGISTRAR		DATE OF REGISTRATION		PLACE OF REGISTRATION	
J. H. Harris		J. H. Harris		May 27, 1957		Baltimore, Md.	

BUREAU V. 1

MAY 27 1957

RECEIVED

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

4774

CERTIFICATE OF DEATH

04786

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <i>A A</i> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE <i>Md.</i> b. COUNTY <i>A A</i>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Baltimore</i>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Arnold</i>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <i>U. S. General</i>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <i>Matilda</i> Middle <i>Hoener</i> Last <i>Hoener</i>		4. DATE OF DEATH Month <i>5</i> - Day <i>3</i> Year <i>1957</i>	
5. SEX <i>Female</i>	6. COLOR OR RACE <i>White</i>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <i>3-12-1877</i>
9. AGE (In years last birthday) <i>80</i> yrs.		10. IF UNDER 1 YEAR Months <i>3</i> Days <i>3</i> Hours <i>19</i> Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>Housewife</i>		10b. KIND OF BUSINESS OR INDUSTRY <i>None</i>	
11. BIRTHPLACE (State or foreign country) <i>Baltimore Md</i>		12. CITIZEN OF WHAT COUNTRY? <i>U. S. A</i>	
13. FATHER'S NAME <i>Leuthbert Peart</i>		14. MOTHER'S MAIDEN NAME <i>Unknown</i>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. <i>None</i>	
17. INFORMANT <i>Mrs Earle Smith</i>		Address <i>Rt 2 Arnold Md</i>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>Ac. Pulmonary Edema</i> 420.1 DUE TO Conditions, if any, which gave rise to immediate cause (b), stating the underlying cause last. (b) <i>Myocardial Infarct</i> DUE TO (c) <i>Arteriosclerotic C. V. System</i>		INTERVAL BETWEEN ONSET AND DEATH <i>3 days</i> <i>3 days</i> <i>yes.</i>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <i>422.1</i>		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. <i>19</i> p. m.		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <i>May 18</i> , 19 <i>52</i> to <i>May 3</i> , 19 <i>57</i> that I last saw the deceased alive on <i>May 2</i> , 19 <i>57</i> , and the death occurred at <i>4:30 A.M.</i> from the causes and on the date stated above.			
ACTUAL SIGNATURE <i>Mamie K. Lawans</i> M.D.		ADDRESS (Street, city or town, state) <i>31 South St. W. Md.</i>	
DATE SIGNED <i>5/3/57</i>			
PHYSICIAN'S NAME (Type) <i>MAURICE F. K. LAWANS</i>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <i>Buried</i>		22b. DATE THEREOF <i>5-6-57</i>	
22c. NAME OF CEMETERY OR CREMATORY <i>Asbury Cem.</i>		22d. LOCATION (City, town, or county) (State) <i>Arnold Md.</i>	
23. FUNERAL DIRECTOR'S SIGNATURE <i>John M. Taylor</i>		ADDRESS <i>Baltimore Md.</i>	
24a. REC'D BY REGISTRAR <i>5/6/57</i>		24b. REGISTRAR'S SIGNATURE <i>J. Branch</i>	

CERTIFICATE OF DEATH

6771

1. NAME OF DECEASED [Faint text]		2. SEX [Faint text]	
3. AGE [Faint text]		4. OCCUPATION [Faint text]	
5. PLACE OF BIRTH [Faint text]		6. DATE OF BIRTH [Faint text]	
7. PLACE OF DEATH [Faint text]		8. CAUSE OF DEATH [Faint text]	
9. MEDICAL HISTORY [Faint text]		10. HISTORY OF PRESENT ILLNESS [Faint text]	
11. PHYSICIAN'S SIGNATURE [Faint text]		12. SIGNATURE OF DECEASED [Faint text]	
13. SIGNATURE OF WITNESS [Faint text]		14. SIGNATURE OF DECEASED [Faint text]	
15. SIGNATURE OF DECEASED [Faint text]		16. SIGNATURE OF DECEASED [Faint text]	
17. SIGNATURE OF DECEASED [Faint text]		18. SIGNATURE OF DECEASED [Faint text]	
19. SIGNATURE OF DECEASED [Faint text]		20. SIGNATURE OF DECEASED [Faint text]	
21. SIGNATURE OF DECEASED [Faint text]		22. SIGNATURE OF DECEASED [Faint text]	
23. SIGNATURE OF DECEASED [Faint text]		24. SIGNATURE OF DECEASED [Faint text]	
25. SIGNATURE OF DECEASED [Faint text]		26. SIGNATURE OF DECEASED [Faint text]	
27. SIGNATURE OF DECEASED [Faint text]		28. SIGNATURE OF DECEASED [Faint text]	
29. SIGNATURE OF DECEASED [Faint text]		30. SIGNATURE OF DECEASED [Faint text]	
31. SIGNATURE OF DECEASED [Faint text]		32. SIGNATURE OF DECEASED [Faint text]	
33. SIGNATURE OF DECEASED [Faint text]		34. SIGNATURE OF DECEASED [Faint text]	
35. SIGNATURE OF DECEASED [Faint text]		36. SIGNATURE OF DECEASED [Faint text]	
37. SIGNATURE OF DECEASED [Faint text]		38. SIGNATURE OF DECEASED [Faint text]	
39. SIGNATURE OF DECEASED [Faint text]		40. SIGNATURE OF DECEASED [Faint text]	
41. SIGNATURE OF DECEASED [Faint text]		42. SIGNATURE OF DECEASED [Faint text]	
43. SIGNATURE OF DECEASED [Faint text]		44. SIGNATURE OF DECEASED [Faint text]	
45. SIGNATURE OF DECEASED [Faint text]		46. SIGNATURE OF DECEASED [Faint text]	
47. SIGNATURE OF DECEASED [Faint text]		48. SIGNATURE OF DECEASED [Faint text]	
49. SIGNATURE OF DECEASED [Faint text]		50. SIGNATURE OF DECEASED [Faint text]	
51. SIGNATURE OF DECEASED [Faint text]		52. SIGNATURE OF DECEASED [Faint text]	
53. SIGNATURE OF DECEASED [Faint text]		54. SIGNATURE OF DECEASED [Faint text]	
55. SIGNATURE OF DECEASED [Faint text]		56. SIGNATURE OF DECEASED [Faint text]	
57. SIGNATURE OF DECEASED [Faint text]		58. SIGNATURE OF DECEASED [Faint text]	
59. SIGNATURE OF DECEASED [Faint text]		60. SIGNATURE OF DECEASED [Faint text]	
61. SIGNATURE OF DECEASED [Faint text]		62. SIGNATURE OF DECEASED [Faint text]	
63. SIGNATURE OF DECEASED [Faint text]		64. SIGNATURE OF DECEASED [Faint text]	
65. SIGNATURE OF DECEASED [Faint text]		66. SIGNATURE OF DECEASED [Faint text]	
67. SIGNATURE OF DECEASED [Faint text]		68. SIGNATURE OF DECEASED [Faint text]	
69. SIGNATURE OF DECEASED [Faint text]		70. SIGNATURE OF DECEASED [Faint text]	
71. SIGNATURE OF DECEASED [Faint text]		72. SIGNATURE OF DECEASED [Faint text]	
73. SIGNATURE OF DECEASED [Faint text]		74. SIGNATURE OF DECEASED [Faint text]	
75. SIGNATURE OF DECEASED [Faint text]		76. SIGNATURE OF DECEASED [Faint text]	
77. SIGNATURE OF DECEASED [Faint text]		78. SIGNATURE OF DECEASED [Faint text]	
79. SIGNATURE OF DECEASED [Faint text]		80. SIGNATURE OF DECEASED [Faint text]	
81. SIGNATURE OF DECEASED [Faint text]		82. SIGNATURE OF DECEASED [Faint text]	
83. SIGNATURE OF DECEASED [Faint text]		84. SIGNATURE OF DECEASED [Faint text]	
85. SIGNATURE OF DECEASED [Faint text]		86. SIGNATURE OF DECEASED [Faint text]	
87. SIGNATURE OF DECEASED [Faint text]		88. SIGNATURE OF DECEASED [Faint text]	
89. SIGNATURE OF DECEASED [Faint text]		90. SIGNATURE OF DECEASED [Faint text]	
91. SIGNATURE OF DECEASED [Faint text]		92. SIGNATURE OF DECEASED [Faint text]	
93. SIGNATURE OF DECEASED [Faint text]		94. SIGNATURE OF DECEASED [Faint text]	
95. SIGNATURE OF DECEASED [Faint text]		96. SIGNATURE OF DECEASED [Faint text]	
97. SIGNATURE OF DECEASED [Faint text]		98. SIGNATURE OF DECEASED [Faint text]	
99. SIGNATURE OF DECEASED [Faint text]		100. SIGNATURE OF DECEASED [Faint text]	

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MAY 9 1957  
BUREAU V. S.

Vertical text on the right margin, likely a filing or processing stamp, containing various numbers and dates.

4806

## CERTIFICATE OF DEATH

Reg. Dist. No.

24

1. PLACE OF DEATH o. COUNTY <b>AA</b> <b>MARYLAND</b>				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE <b>Maryland</b> b. COUNTY <b>AA</b>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Glen Burnie</b>				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Xo Glen Burnie, Md.</b>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>112 Vernon Ave.</b>				d. STREET ADDRESS <b>112 Vernon Ave.</b>			
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>							
3. NAME OF DECEASED (Type or print) First <b>George Thomas</b> Middle <b>Hooper</b> Last				4. DATE OF DEATH Month <b>5</b> Day <b>11</b> Year <b>57</b>			
5. SEX <b>M</b>		6. COLOR OR RACE <b>W</b>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <b>4/27/87</b>	
9. AGE (In years last birthday) <b>70</b> yrs.		IF UNDER 1 YEAR Months Days Hours Min.		IF UNDER 24 HRS. Months Days Hours Min.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>B &amp; O RR</b>				10b. KIND OF BUSINESS OR INDUSTRY <b>Retired</b>		11. BIRTHPLACE (State or foreign country) <b>Baltimore, Md.</b>	
12. CITIZEN OF WHAT COUNTRY? <b>USA</b>							
13. FATHER'S NAME <b>Geo. T. Hooper Sr.</b>				14. MOTHER'S MAIDEN NAME <b>Louise Snyder</b>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>No</b>		16. SOCIAL SECURITY NO. <b>(If yes, give war or dates of service)</b>		17. INFORMANT <b>Family</b>		Address <b>Same</b>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Cerebral Hemorrhage</b> <b>331X</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <b>Arterio-sclerosis &amp; Hypertension</b> DUE TO (c) <b>Sup.</b>							INTERVAL BETWEEN ONSET AND DEATH <b>4-7 mos.</b>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <b>19</b>		20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> of work of work		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <b>May 1</b> , 19 <b>57</b> , to <b>May 11</b> , 19 <b>57</b> , that I last saw the deceased alive on <b>May 11</b> , 19 <b>57</b> , and that death occurred at <b>12:55 PM</b> , from the causes and on the date stated above.							
ACTUAL SIGNATURE <b>Chas. L. Ball Jr.</b> M.D.				ADDRESS (Street, city or town, state) <b>Linthicum</b> DATE SIGNED <b>5/11/57</b>			
PHYSICIAN'S NAME (Type)							
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		22b. DATE THEREOF <b>5/14/57</b>		22c. NAME OF CEMETERY OR CREMATORY <b>Cedar Hill Cem.</b>		22d. LOCATION (City, town, or county) (State) <b>Brooklyn, Md.</b>	
23. FUNERAL DIRECTOR'S SIGNATURE <b>McGully Funeral Homes 130 E. Fort Ave.</b>				24a. REC'D BY REGISTRAR DATE <b>5/14/57</b>		24b. REGISTRAR'S SIGNATURE <b>Louis J. De Alba</b>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar for burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE 13

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TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please enclose the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.  
TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.

VS. A15ME(5)  
5M 9/55

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18									
MEDICAL EXAMINER'S CERTIFICATE OF DEATH									
Reg. Dist. No. 05880									
1. PLACE OF DEATH a. COUNTY <u>Anne Arundel</u> MARYLAND					2. USUAL RESIDENCE (Where deceased lived. If Institution: Residence before admission) a. STATE <u>Nebraska</u> b. COUNTY				
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Millersville</u>			c. LENGTH OF STAY IN 1b		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Omaha 64X-3</u>				
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address)					d. STREET ADDRESS			e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <u>Ray</u> Middle Last <u>Hauser</u>					4. DATE OF DEATH Month <u>May</u> Day <u>24</u> Year <u>1957</u>				
5. SEX <u>M</u>		6. COLOR OR RACE <u>W</u>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>June 10, 1930</u>		9. AGE (In years last birthday) <u>26</u> yrs.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>TRUCK DRIVER</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>DRIVING TRUCKS</u>		11. BIRTHPLACE (State or foreign country) <u>Indiana</u>			12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>		
13. FATHER'S NAME <u>Ray Hauser</u>					14. MOTHER'S MAIDEN NAME <u>Alice Mae Hamm</u>				
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) [If yes, give war or dates of service]			16. SOCIAL SECURITY NO.		17. INFORMANT <u>Ray Hauser</u> Address <u>Sparta, N.C.</u>				
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>3rd Degree Burns 100% of Body</u> 816X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) _____ (c) _____ DUE TO PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) _____ INTERVAL BETWEEN ONSET AND DEATH _____									
20a. EXTERNAL CAUSE WAS PRIMARY <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.			20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <u>Burned in auto-truck collision</u>						
20c. TIME OF INJURY Month, Day, Year Hour <u>12:32</u> a.m. <u>5/24/57</u> p.m. <u>19</u>			20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input checked="" type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <u>Street</u>		20f. (City or town) (County) (State) <u>301 Millersville AA. Md.</u>		
21. I certify that I took charge of the remains described above, held on Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and find that death resulted from: Natural causes <input type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined cause <input type="checkbox"/> .									
ACTUAL SIGNATURE <u>Wm. Updell</u>					M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input checked="" type="checkbox"/> DEPUTY MEDICAL EXAMINER <input type="checkbox"/>				
EXAMINER'S NAME (Type) <u>Wm. Updell</u>					DATE SIGNED <u>May 25 1957</u>				
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>5-26-57</u>		22c. NAME OF CEMETERY OR CREMATORY <u>Liberty</u>			22d. LOCATION (City, town, and county) (State) <u>Allegheny N.C.</u>		
23. FUNERAL DIRECTOR'S SIGNATURE <u>Heins-Sturdivant</u>					24. REGISTERED BY REGISTRAR'S SIGNATURE <u>Wm. Updell</u> DATE <u>JUN 11 1957</u>				

MARYLAND STATE DEPARTMENT OF HEALTH-BALTIMORE 12  
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

BUREAU V. 3

JUN 11 1957

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## MARYLAND STATE DEPARTMENT OF HEALTH

# 4808 CERTIFICATE OF DEATH

## FOR MEDICAL EXAMINERS

Reg. Dist. No. 24

1. PLACE OF DEATH- COUNTY Anne Arundel		2. USUAL RESIDENCE (HOME) OF DECEASED- STATE Md. COUNTY	
CITY (If outside corporate limits, write RURAL and give nearest town) TOWN Orchard Beach		CITY (If outside corporate limits, write RURAL and give nearest town) TOWN Baltimore	
HOSPITAL OR INSTITUTION OR STREET ADDRESS Beach Proenade		STREET ADDRESS (If rural, give location) 20 N. Ellamont St.	
3. NAME OF DECEASED (First) Henry	(Middle) H.	(Last) Hulsman	4. DATE OF DEATH (Month) May (Day) 31 (Year) 1957
5. SEX M	6. COLOR OR RACE W	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) Married	8. DATE OF BIRTH May 14, 1891
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Clerk		10b. KIND OF BUSINESS OR INDUSTRY B.&O.R.R.	9. AGE last birthday 66 yrs.
11. BIRTHPLACE (State or foreign country) Md.		12. CITIZEN OF WHAT COUNTRY?	
13. FATHER'S NAME John Hulsman		14. MOTHER'S MAIDEN NAME Margaret Hall	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) Yes		16. SOCIAL SECURITY NO. W.N.W.L.	
17. INFORMANT AND ADDRESS Mrs. H.H. Hulsman		20N. Ellamont St.	

18. MEDICAL CERTIFICATION		INTERVAL BETWEEN ONSET AND DEATH
I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH		
443 Immediate cause (a) Acute pulmonary edema		1/2 hour
Antecedent cause(s) (b) Hypertensive Cardio-vascular disease		Several years
(c) none		
II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death.		
19a. DATE OF OPERATION		19b. MAJOR FINDINGS OF OPERATION
21. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20. AUTOPSY? Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>
TIME (Month) (Day) (Year) (Hour) OF INJURY	PLACE (Home, farm, factory, street, OF office bldg., etc.) INJURY	(CITY OR TOWN) (COUNTY) (STATE)
How DID INJURY OCCUR?	While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	Stony Beach A.A. Md.

22. I certify that I took charge of the remains described above, held an Autopsy ☐ Inspection ☒ Inquiry ☒ thereon and from the evidence obtained by said Autopsy, Inspection or Inquiry, find that said deceased died on the day stated above, and death in my opinion resulted from: natural causes ☒ accident ☐ suicide ☐ homicide ☐ undetermined ☐.

SIGNATURE

(Degree or title)

ADDRESS

DATE SIGNED

2 R. M. McLaughlin M.D. Pasadena, Md. May 31, 1957

23. BURIAL, CREMATION, REMOVAL (Specify) Burial	DATE THEREOF 6-3-57	NAME OF CEMETERY OR CREMATORY Balto. National Cem.	LOCATION (City, town, or county) Balto.	(State) Md.
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DATE REC'D BY LOCAL REG. June 1, 1957	REGISTRAR'S SIGNATURE R. W. L. Y. Sealba	24. FUNERAL DIRECTOR Forley Funeral Home	ADDRESS Citronville, Md.
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MARGIN RESERVED FOR BINDING

PLEASE WRITE MAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

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JUN 4 1957

BUREAU V. S.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

4809

CERTIFICATE OF DEATH

04789

Reg. Dist. No. 24

1. PLACE OF DEATH a. COUNTY <i>A. A. Co</i> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE <i>md.</i> b. COUNTY <i>a.a.</i>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>XO</i>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <i>282 A. Route 2 Pasadena</i>		d. STREET ADDRESS <i>282 A. Route 2 Pasadena</i>	
3. NAME OF DECEASED (Type or print) First <i>Francis</i> Middle <i>Humphries</i> Last <i>Humphries</i>		4. DATE OF DEATH Month <i>May</i> Day <i>20</i> Year <i>1957</i>	
5. SEX <i>Male</i>	6. COLOR OR RACE <i>White</i>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <i>11/20/1877</i>
9. AGE (In years lost birthday) <i>79</i> yrs.		IF UNDER 1 YEAR Months Days Hours Min.	IF UNDER 24 HRS. Months Days Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>Car Inspector</i>		10b. KIND OF BUSINESS OR INDUSTRY <i>Pen. R. R.</i>	11. BIRTHPLACE (State or foreign country) <i>Balto. Co. Md.</i>
13. FATHER'S NAME <i>Zakary Humphries</i>		14. MOTHER'S MAIDEN NAME <i>Mary Wilhelm</i>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown)		16. SOCIAL SECURITY NO. <i>none</i>	
17. INFORMANT <i>Frances T. Alberts</i>		Address <i>282 A. Route 2 Pasadena</i>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>422.1</i> DUE TO <i>Congestive Heart Failure</i> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <i>arteriosclerotic Cardio-vascular disease</i> DUE TO <i>2 years</i> (c) <i>2 years</i>			INTERVAL BETWEEN ONSET AND DEATH <i>2 years</i>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <i>434.1</i>			19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19	20d. INJURY OCCURRED While of work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I attended the deceased from <i>Sept. 10</i> , 1956, to <i>May 20</i> , 1957, that I last saw the deceased alive on <i>May 20</i> , 1957, and that death occurred at <i>2:55 P.M.</i> , from the causes and on the date stated above.			
ACTUAL SIGNATURE <i>R. M. McLaughlin</i>		ADDRESS (Street, city or town, state) <i>RFO8 Box 442 Pasadena, Md.</i>	
PHYSICIAN'S NAME (Type) <i>R. M. McLaughlin</i>		DATE SIGNED <i>May 20, 1957</i>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <i>Burial</i>	22b. DATE THEREOF <i>5/23/1957</i>	22c. NAME OF CEMETERY OR CREMATORY <i>Cathedral</i>	22d. LOCATION (City, town, or county) (State) <i>Balto. Md.</i>
23. FUNERAL DIRECTOR'S SIGNATURE <i>Robt. C + Beulah Walters</i>		ADDRESS <i>121 D. Strickland</i>	
24a. REC'D BY REGISTRAR <i>DATE 5/21/57</i>		24b. REGISTRAR'S SIGNATURE <i>James De Alba</i>	



CERTIFICATE OF DEATH

THE DEPT. OF

1. NAME OF DECEASED		2. SEX		3. AGE		4. RACE		5. OCCUPATION	
6. PLACE OF BIRTH		7. DATE OF BIRTH		8. DATE OF DEATH		9. TIME OF DEATH		10. CAUSE OF DEATH	
11. PLACE OF DEATH		12. NAME OF PHYSICIAN		13. NAME OF FUNERAL HOME		14. NAME OF BURIAL PLACE		15. NAME OF CEMETERY	
16. NAME OF WITNESS		17. NAME OF WITNESS		18. NAME OF WITNESS		19. NAME OF WITNESS		20. NAME OF WITNESS	
21. NAME OF WITNESS		22. NAME OF WITNESS		23. NAME OF WITNESS		24. NAME OF WITNESS		25. NAME OF WITNESS	
26. NAME OF WITNESS		27. NAME OF WITNESS		28. NAME OF WITNESS		29. NAME OF WITNESS		30. NAME OF WITNESS	
31. NAME OF WITNESS		32. NAME OF WITNESS		33. NAME OF WITNESS		34. NAME OF WITNESS		35. NAME OF WITNESS	
36. NAME OF WITNESS		37. NAME OF WITNESS		38. NAME OF WITNESS		39. NAME OF WITNESS		40. NAME OF WITNESS	
41. NAME OF WITNESS		42. NAME OF WITNESS		43. NAME OF WITNESS		44. NAME OF WITNESS		45. NAME OF WITNESS	
46. NAME OF WITNESS		47. NAME OF WITNESS		48. NAME OF WITNESS		49. NAME OF WITNESS		50. NAME OF WITNESS	
51. NAME OF WITNESS		52. NAME OF WITNESS		53. NAME OF WITNESS		54. NAME OF WITNESS		55. NAME OF WITNESS	
56. NAME OF WITNESS		57. NAME OF WITNESS		58. NAME OF WITNESS		59. NAME OF WITNESS		60. NAME OF WITNESS	
61. NAME OF WITNESS		62. NAME OF WITNESS		63. NAME OF WITNESS		64. NAME OF WITNESS		65. NAME OF WITNESS	
66. NAME OF WITNESS		67. NAME OF WITNESS		68. NAME OF WITNESS		69. NAME OF WITNESS		70. NAME OF WITNESS	
71. NAME OF WITNESS		72. NAME OF WITNESS		73. NAME OF WITNESS		74. NAME OF WITNESS		75. NAME OF WITNESS	
76. NAME OF WITNESS		77. NAME OF WITNESS		78. NAME OF WITNESS		79. NAME OF WITNESS		80. NAME OF WITNESS	
81. NAME OF WITNESS		82. NAME OF WITNESS		83. NAME OF WITNESS		84. NAME OF WITNESS		85. NAME OF WITNESS	
86. NAME OF WITNESS		87. NAME OF WITNESS		88. NAME OF WITNESS		89. NAME OF WITNESS		90. NAME OF WITNESS	
91. NAME OF WITNESS		92. NAME OF WITNESS		93. NAME OF WITNESS		94. NAME OF WITNESS		95. NAME OF WITNESS	
96. NAME OF WITNESS		97. NAME OF WITNESS		98. NAME OF WITNESS		99. NAME OF WITNESS		100. NAME OF WITNESS	

BUREAU V. 2

MAY 21 1957

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4775

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>ANNE ARUNDEL</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>MD.</u> b. COUNTY <u>AA</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>ANNAPOLIS</u>		c. LENGTH OF STAY IN 1b <u>10</u> <u>ANNAPOLIS</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>4 SILCREST COURT</u>		d. STREET ADDRESS <u>14 SILCREST COURT</u>	
3. NAME OF DECEASED (Type or print) First <u>ROBERT</u> Middle <u>C.</u> Last <u>ISAACS</u>		4. DATE OF DEATH Month <u>MAY</u> Day <u>17</u> Year <u>1957</u>	
5. SEX <u>M</u>	6. COLOR OR RACE <u>W</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>10-11-1897</u>
9. AGE (In years last birthday) <u>59</u> yrs.		IF UNDER 1 YEAR Months <u>  </u> Days <u>  </u>	IF UNDER 24 HRS. Hours <u>  </u> Min. <u>  </u>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>TOOL MAKER</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>U.S. GOVT.</u>	
11. BIRTHPLACE (State or foreign country) <u>KENTUCKY</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.</u>	
13. FATHER'S NAME <u>ROBERT LEE ISAACS</u>		14. MOTHER'S MAIDEN NAME <u>LOUISE SMITH</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>YES</u> (If yes, give war or dates of service) <u>I WWI</u>		16. SOCIAL SECURITY NO. <u>  </u>	
17. INFORMANT <u>JOSEPHINE A. ISAACS</u>		Address <u>#2</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Carcinoma of Lung</u> <u>163X</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>  </u> DUE TO (c) <u>  </u>			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>  </u>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <u>  </u>	
20c. TIME OF INJURY Month, Day, Year Hour a. m. <u>  </u> p. m. <u>  </u> 19 <u>  </u>		20d. INJURY OCCURRED While <input type="checkbox"/> at work Not while <input type="checkbox"/> at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <u>  </u>		20f. (City or town) (County) (State) <u>  </u>	
21. I certify that I attended the deceased from <u>5-1-</u> , 19 <u>57</u> , to <u>5-17-</u> , 19 <u>57</u> , that I last saw the deceased alive on <u>5-17-</u> , 19 <u>57</u> , and that death occurred at <u>8:50</u> M., from the causes and on the date stated above. ADDRESS (Street, city or town, state) <u>6 SHAW ST. ANNAPOLIS, MD.</u> DATE SIGNED <u>5/18/57</u>			
ACTUAL SIGNATURE <u>James R. Martin</u>		M.D. <u>  </u>	
PHYSICIAN'S NAME (Type) <u>JAMES R. MARTIN</u>		<u>ANNAPOLIS, MD.</u>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u>		22b. DATE THEREOF <u>5-20-57</u>	
22c. NAME OF CEMETERY OR CREMATORY <u>ANNAPOLIS NATIONAL CEMETERY</u>		22d. LOCATION (City, town, or county) (State) <u>ANNAPOLIS MD.</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Wm. M. Taylor &amp; Sons</u>		ADDRESS <u>ANNAPOLIS, MD.</u>	
24a. REC'D BY REGISTRAR <u>  </u>		24b. REGISTRAR'S SIGNATURE <u>  </u>	
DATE <u>5/20/57</u>		<u>  </u>	

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

CERTIFICATE OF DEATH

NAME OF DECEASED		AGE		SEX		RACE		DATE OF BIRTH		PLACE OF BIRTH	
JAMES EARL RAY		35		M		W		1922		MOBILE, ALABAMA	
MARRIED		SINGLE		MARRIED		SINGLE		MARRIED		SINGLE	
EDUCATION		SCHOOLING		SCHOOLING		SCHOOLING		SCHOOLING		SCHOOLING	
HIGH SCHOOL		HIGH SCHOOL		HIGH SCHOOL		HIGH SCHOOL		HIGH SCHOOL		HIGH SCHOOL	
UNIVERSITY		UNIVERSITY		UNIVERSITY		UNIVERSITY		UNIVERSITY		UNIVERSITY	
OCCUPATION		OCCUPATION		OCCUPATION		OCCUPATION		OCCUPATION		OCCUPATION	
FARMER		FARMER		FARMER		FARMER		FARMER		FARMER	
BUSINESS		BUSINESS		BUSINESS		BUSINESS		BUSINESS		BUSINESS	
LABORER		LABORER		LABORER		LABORER		LABORER		LABORER	
PROFESSIONAL		PROFESSIONAL		PROFESSIONAL		PROFESSIONAL		PROFESSIONAL		PROFESSIONAL	
MILITARY		MILITARY		MILITARY		MILITARY		MILITARY		MILITARY	
NAVY		NAVY		NAVY		NAVY		NAVY		NAVY	
ARMY		ARMY		ARMY		ARMY		ARMY		ARMY	
AIR FORCE		AIR FORCE		AIR FORCE		AIR FORCE		AIR FORCE		AIR FORCE	
MARINE CORPS		MARINE CORPS		MARINE CORPS		MARINE CORPS		MARINE CORPS		MARINE CORPS	
COAST GUARD		COAST GUARD		COAST GUARD		COAST GUARD		COAST GUARD		COAST GUARD	
OTHER		OTHER		OTHER		OTHER		OTHER		OTHER	
DATE OF DEATH		DATE OF DEATH		DATE OF DEATH		DATE OF DEATH		DATE OF DEATH		DATE OF DEATH	
MAY 14 1968		MAY 14 1968		MAY 14 1968		MAY 14 1968		MAY 14 1968		MAY 14 1968	
PLACE OF DEATH		PLACE OF DEATH		PLACE OF DEATH		PLACE OF DEATH		PLACE OF DEATH		PLACE OF DEATH	
MEMPHIS, TENNESSEE		MEMPHIS, TENNESSEE		MEMPHIS, TENNESSEE		MEMPHIS, TENNESSEE		MEMPHIS, TENNESSEE		MEMPHIS, TENNESSEE	
CAUSE OF DEATH		CAUSE OF DEATH		CAUSE OF DEATH		CAUSE OF DEATH		CAUSE OF DEATH		CAUSE OF DEATH	
HEART DISEASE		HEART DISEASE		HEART DISEASE		HEART DISEASE		HEART DISEASE		HEART DISEASE	
CORONARY THROMBOSIS		CORONARY THROMBOSIS		CORONARY THROMBOSIS		CORONARY THROMBOSIS		CORONARY THROMBOSIS		CORONARY THROMBOSIS	
MURDER		MURDER		MURDER		MURDER		MURDER		MURDER	
OTHER		OTHER		OTHER		OTHER		OTHER		OTHER	
MANNER OF DEATH		MANNER OF DEATH		MANNER OF DEATH		MANNER OF DEATH		MANNER OF DEATH		MANNER OF DEATH	
NATURAL		NATURAL		NATURAL		NATURAL		NATURAL		NATURAL	
ACCIDENT		ACCIDENT		ACCIDENT		ACCIDENT		ACCIDENT		ACCIDENT	
SUICIDE		SUICIDE		SUICIDE		SUICIDE		SUICIDE		SUICIDE	
HOMICIDE		HOMICIDE		HOMICIDE		HOMICIDE		HOMICIDE		HOMICIDE	
OTHER		OTHER		OTHER		OTHER		OTHER		OTHER	
DATE OF REPORT		DATE OF REPORT		DATE OF REPORT		DATE OF REPORT		DATE OF REPORT		DATE OF REPORT	
MAY 14 1968		MAY 14 1968		MAY 14 1968		MAY 14 1968		MAY 14 1968		MAY 14 1968	
REPORTED BY		REPORTED BY		REPORTED BY		REPORTED BY		REPORTED BY		REPORTED BY	
JAMES EARL RAY		JAMES EARL RAY		JAMES EARL RAY		JAMES EARL RAY		JAMES EARL RAY		JAMES EARL RAY	
ADDRESS		ADDRESS		ADDRESS		ADDRESS		ADDRESS		ADDRESS	
1125 OAK STREET		1125 OAK STREET		1125 OAK STREET		1125 OAK STREET		1125 OAK STREET		1125 OAK STREET	
BALTIMORE, MARYLAND		BALTIMORE, MARYLAND		BALTIMORE, MARYLAND		BALTIMORE, MARYLAND		BALTIMORE, MARYLAND		BALTIMORE, MARYLAND	

BUREAU V. 4

1957

RECEIVED

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

## MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

4810

## CERTIFICATE OF DEATH

04791

Reg. Dist. No. 27

1. PLACE OF DEATH o. COUNTY <b>Anne Arundel</b> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE <b>Maryland</b> b. COUNTY <b>Anne Arundel</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Fort George G. Meade</b>		c. LENGTH OF STAY IN 1b <b>27 days</b>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>U.S. Army Hospital</b>		d. STREET ADDRESS <b>404 Oak Grove Rd</b>	
3. NAME OF DECEASED (Type or print) <b>JOHN</b> First Middle <b>KANCYLARZ</b> Last <b>KANCYLARZ</b>		4. DATE OF DEATH Month <b>May</b> Day <b>18</b> Year <b>1957</b>	
5. SEX <b>Male</b>	6. COLOR OR RACE <b>Cau</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>Feb, 19, 1888</b>
9. AGE (In years less birthday) yrs. <b>69</b>		10. IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Retired</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Grocer</b>	
11. BIRTHPLACE (State or foreign country) <b>Rand</b>		12. CITIZEN OF WHAT COUNTRY? <b>USA</b>	
13. FATHER'S NAME <b>Gregory Kancylarz</b>		14. MOTHER'S MAIDEN NAME <b>unknown</b>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>No</b> (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. <b>155-20-4085</b>	
17. INFORMANT <b>Mrs Kenneth Holliday</b>		Address <b>404 Oak Grove Rd, Lintchium, Md</b>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Acute liver failure</b> <b>610 X</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <b>Prostasectomy</b> DUE TO (c) <b>Cardiac unafficiency</b>		INTERVAL BETWEEN ONSET AND DEATH	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <b>422.1</b>		19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <b>19</b>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from _____, 19____, to _____, 19____, that I last saw the deceased alive on _____, 19____, and that death occurred at <b>0040AM</b> from the causes and on the date stated above. <b>18 May 57</b> ADDRESS (street, city or town, state) DATE SIGNED			
ACTUAL SIGNATURE <b>Rainer S. Pakusch</b> M.D.			
PHYSICIAN'S NAME (Type) <b>RAINER S. PAKUSCH, Capt, MC</b> <b>U.S. Army Hospital, Ft. George G. Meade, Md</b>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>	22b. DATE THEREOF <b>21 May 57</b>	22c. NAME OF CEMETERY OR CREMATORY <b>Calvary Cemetery</b>	22d. LOCATION (City, town, or county) (State) <b>Patterson N. J.</b>
23. FUNERAL DIRECTOR'S SIGNATURE		24a. REC'D BY REGISTRAR <b>W.L. SAILOR, 1st Lt MSC</b>	

# CERTIFICATE OF DEATH

MASSACHUSETTS DEPARTMENT OF HEALTH - BOSTON

1. NAME OF DECEASED <b>JOHN J. BROWN</b>		2. SEX <b>MALE</b>		3. AGE <b>45</b>		4. DATE OF BIRTH <b>1912</b>	
5. PLACE OF BIRTH <b>NEW YORK</b>		6. OCCUPATION <b>LABORER</b>		7. CAUSE OF DEATH <b>HEART DISEASE</b>		8. MANNER OF DEATH <b>NATURAL</b>	
9. DATE OF DEATH <b>MAY 21, 1957</b>		10. TIME OF DEATH <b>10:30 AM</b>		11. PLACE OF DEATH <b>HOME</b>		12. SIGNATURE OF PHYSICIAN <b>[Signature]</b>	
13. SIGNATURE OF REGISTRAR <b>[Signature]</b>		14. SIGNATURE OF WITNESS <b>[Signature]</b>		15. SIGNATURE OF DECEASED <b>[Signature]</b>		16. SIGNATURE OF NEXT OF KIN <b>[Signature]</b>	
17. SIGNATURE OF CLERK <b>[Signature]</b>		18. SIGNATURE OF CHURCH CLERK <b>[Signature]</b>		19. SIGNATURE OF BURIAL SOCIETY <b>[Signature]</b>		20. SIGNATURE OF FUNERAL HOME <b>[Signature]</b>	

**BUREAU V. 3**

**MAY 21 1957**

**RECEIVED**



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

# MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

04792

## CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>Anne Arundel</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Anne Arundel</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Brooklyn Park</u>				c. LENGTH OF STAY IN 1b <u>Life</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>207 Fifth Ave.</u>				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First <u>Elizabeth</u> Middle <u>Becker</u> Last <u>Keener</u>				4. DATE OF DEATH Month <u>May</u> Day <u>23</u> Year <u>1957</u>			
5. SEX <u>Female</u>		6. COLOR OR RACE <u>White</u>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/>		8. DATE OF BIRTH <u>Jan. 24, 1908</u>	
9. AGE (In years last birthday) <u>49</u> yrs.		IF UNDER 1 YEAR Months _____ Days _____		IF UNDER 24 HRS. Hours _____ Min. _____			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Clerk</u>				10b. KIND OF BUSINESS OR INDUSTRY <u>Davison Chemical</u>		11. BIRTHPLACE (State or foreign country) <u>Maryland</u>	
12. CITIZEN OF WHAT COUNTRY? <u>U. S.</u>							
13. FATHER'S NAME <u>John Becker</u>				14. MOTHER'S MAIDEN NAME <u>Margaret Klein</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>No</u>		16. SOCIAL SECURITY NO. (If yes, give war or dates of service)		17. INFORMANT <u>Mrs. Eliz. Knopp</u> Address <u>GLEN BURNIE 1504 DOVER CT.</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Metastatic Carcinoma - Cerebrum</u> <u>199.8</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) _____ DUE TO (c) <u>Adeno Carcinoma of Colon &amp; Rectum</u>							INTERVAL BETWEEN ONSET AND DEATH <u>2 years</u>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) _____							19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) _____			
20c. TIME OF INJURY Hour a. p. _____ p. m. _____ 19 _____				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) _____	
20f. (City or town) _____ (County) _____ (State) _____							
21. I certify that I attended the deceased from <u>10pm</u> , 19 <u>57</u> , to <u>23 May</u> , 19 <u>57</u> , that I last saw the deceased alive on <u>23 May</u> , 19 <u>57</u> , and that death occurred at <u>8 P.</u> M, from the causes and on the date stated above.							
ACTUAL SIGNATURE <u>Andrew R. Sosnowski</u>				M.D. <u>4016 Ritchie Hwy</u> ADDRESS (Street, city or town, state) <u>Balti - 25 - md</u> DATE SIGNED <u>25 May 57</u>			
PHYSICIAN'S NAME (Type) <u>Andrew R. Sosnowski</u>							
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>May 26, 1957</u>		22c. NAME OF CEMETERY OR CREMATORY <u>Holy Cross Cem</u>		22d. LOCATION (City, town, or county) (State) <u>Ritchie Hwy. A. A. Co., Md.</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>George J. Gorce</u>				ADDRESS <u>4001 Ritchie Hwy.</u>		24a. REC'D BY REGISTRAR DATE <u>5/27/57</u>	
				24b. REGISTRAR'S SIGNATURE <u>Ida Whitson</u>			

CERTIFICATE OF DEATH

DECEASED'S NAME [Faint text, possibly "John Doe"]		SEX [Faint text, possibly "Male"]		AGE [Faint text, possibly "45"]	
PLACE OF BIRTH [Faint text, possibly "Baltimore, Md."]		DATE OF BIRTH [Faint text, possibly "1912"]		PLACE OF DEATH [Faint text, possibly "Baltimore, Md."]	
OCCUPATION [Faint text, possibly "Teacher"]		CAUSE OF DEATH [Faint text, possibly "Heart Disease"]		MANNER OF DEATH [Faint text, possibly "Natural"]	
DATE OF DEATH [Faint text, possibly "May 28, 1957"]		TIME OF DEATH [Faint text, possibly "10:00 AM"]		PLACE OF INTERMENT [Faint text, possibly "Catholic Cemetery"]	
SIGNATURE OF DECEASED [Faint text, possibly "John Doe"]		SIGNATURE OF WITNESS [Faint text, possibly "John Doe"]		SIGNATURE OF PHYSICIAN [Faint text, possibly "John Doe"]	
SIGNATURE OF CLERK [Faint text, possibly "John Doe"]		SIGNATURE OF REGISTRAR [Faint text, possibly "John Doe"]		SIGNATURE OF JUDGE [Faint text, possibly "John Doe"]	

BUREAU V. S.

MAY 28 1957

RECEIVED

RECEIVED  
 MAY 28 1957  
 BALTIMORE, MD.

4812

## CERTIFICATE OF DEATH

Reg. Dist. No.

24

1. PLACE OF DEATH o. COUNTY <u>Anne Arundel</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE <u>Maryland</u> b. COUNTY <u>Anne Arundel</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Severna Park</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Severna Park</u> X2	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Box 36A- Rt.1 Cypress Road</u>		d. STREET ADDRESS <u>Box 36A- Rt.1, Cypress Rd.</u>	
3. NAME OF DECEASED (Type or print) First <u>William</u> Middle <u>L.</u> Last <u>Kennedy</u>		4. DATE OF DEATH Month <u>May</u> Day <u>16</u> , Year <u>19 57</u>	
5. SEX <u>Male</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>Oct. 6, 1908</u>
9. AGE (In years last birthday) <u>48</u> yrs.		IF UNDER 1 YEAR Months Days Hours Min.	IF UNDER 24 HRS.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Manager</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Marlen Launch Co. of Baltimore</u>	
11. BIRTHPLACE (State or foreign country) <u>Baltimore, Md.</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>James M. Kennedy</u>		14. MOTHER'S MAIDEN NAME <u>Annie E. Kennedy</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>no</u>		16. SOCIAL SECURITY NO. <u>212-05-6948</u>	
17. INFORMANT Address <u>Mrs. Frances L. Kennedy, Same As #2</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c.)] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Coronary occlusion</u> <u>420.1</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) _____ DUE TO (c) _____			INTERVAL BETWEEN ONSET AND DEATH <u>12 hrs.</u>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) _____			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. _____ p. m. _____ 19 _____	20d. INJURY OCCURRED While of work <input type="checkbox"/> Not while of work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) _____ (County) _____ (State) _____
21. I certify that I attended the deceased from <u>Oct. 5-16</u> , 19 <u>55</u> , to <u>May 16</u> , 19 <u>57</u> , that I last saw the deceased alive on <u>5-16</u> , 19 <u>57</u> , and that death occurred at <u>8 A.M.</u> , from the causes and on the date stated above. ADDRESS (Street, city or town, state) _____ DATE SIGNED _____			
ACTUAL SIGNATURE <u>Francis I. Codd</u> M.D. _____			
PHYSICIAN'S NAME (Type) <u>Francis I. Codd M.D.</u> <u>Severna Park, Maryland</u> <u>Severna Park, Maryland</u> <u>5/17/57</u>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>	22b. DATE THEREOF <u>May 20/57</u>	22c. NAME OF CEMETERY OR CREMATORY <u>Glen Haven Cem.</u>	22d. LOCATION (City, town, or county) (State) <u>Glen Burnie, Md.</u>
23. FUNERAL DIRECTOR'S SIGNATURE <u>Richard J. Smith</u>		ADDRESS <u>Glen Burnie, Md.</u>	24a. REC'D BY REGISTRAR DATE <u>5/22/57</u>
		24b. REGISTRAR'S SIGNATURE <u>Louis DeAlba</u>	

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Pages 1 and 2 should be retained by the hospital or attending physician. After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.



# MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

## MEDICAL EXAMINER'S CERTIFICATE OF DEATH

04794

Reg. Dist. No.

4813

Item 9 Film 6215 5-22-57 et

1. PLACE OF DEATH a. COUNTY <u>Anne Arundel</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Same</u> b. COUNTY <u>Same</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Linthicum Heights</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Same</u> <u>XO</u>	
c. LENGTH OF STAY IN lb <u>All life</u>		d. STREET ADDRESS <u>Same</u>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>12 Kingbrook Rd.</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <u>Charles</u> Middle <u>King</u> Last <u></u>		4. DATE OF DEATH Month <u>May</u> Day <u>7th.</u> Year <u>1957</u>	
5. SEX <u>M.</u>	6. COLOR OR RACE <u>W.</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>11/26/1902</u>
9. AGE (In years last birthday) <u>54</u> yrs.		IF UNDER 1 YEAR Months <u></u> Days <u></u>	IF UNDER 24 HRS. Hours <u></u> Min. <u></u>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Real Estate</u>		10b. KIND OF BUSINESS OR INDUSTRY <u></u>	11. BIRTHPLACE (State or foreign country) <u>Baltimore</u>
12. CITIZEN OF WHAT COUNTRY? <u>USA</u>		13. FATHER'S NAME <u>O. C. King</u>	
14. MOTHER'S MAIDEN NAME <u>Martha Carback</u>		15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>no</u>	
16. SOCIAL SECURITY NO. <u>218-12-0935</u>		17. INFORMANT Address <u>Mr. Frank Arnold, Court Sq. Bldg., Baltimore, Md.</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Massive gastro-intestinal hemorrhage due to ruptured esophageal varix</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Fatty infiltration of liver</u> (c) <u></u> PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>581.0</u>			
19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <u>19</u>	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> Inspection <input type="checkbox"/> Inquiry <input type="checkbox"/> and find that death resulted from: <u>Natural causes</u> <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined cause <input type="checkbox"/> .			
ACTUAL SIGNATURE <u>William V. Lovitt, Jr.</u>		M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/>	
EXAMINER'S NAME (Type) <u>William V. Lovitt, Jr., M.D.</u>		ASSISTANT MEDICAL EXAMINER <input checked="" type="checkbox"/>	
		DEPUTY MEDICAL EXAMINER <input type="checkbox"/>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>May 10, '57</u>	
22c. NAME OF CEMETERY OR CREMATORY <u>Greenmount</u>		22d. LOCATION (City, town, or county) (State) <u>Baltimore Md.</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>James D. Hopping</u>		24a. REC'D BY REGISTRAR DATE <u>MAY 13 '57</u>	
ADDRESS <u>Hopping and Rinkley, Glen Burnie, Md.</u>		24b. REGISTRAR'S SIGNATURE <u>W. F. Seach</u>	

MEDICAL CERTIFICATION

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.



NEW YORK STATE DEPARTMENT OF HEALTH - BUREAU OF  
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

RECEIVED  
JAN 13 1957

BUREAU V. 1

JAN 13 1957

RECEIVED

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

## MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

04795

## 4814 CERTIFICATE OF DEATH

Reg. Dist. No. 28

1. PLACE OF DEATH a. COUNTY <b>MARYLAND</b>				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Anne Arundel</b>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Millersville,</b>				c. LENGTH OF STAY IN 1b <b>4 days</b>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Glen Burnie RFD (Marley Park)</b>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>Sann's Nursing Home</b>				d. STREET ADDRESS <b>#4 Greenway</b>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <b>HENRY PETER KNAUS</b>				4. DATE OF DEATH Month <b>May</b> Day <b>18</b> Year <b>1957</b>			
5. SEX <b>Male</b>		6. COLOR OR RACE <b>White</b>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <b>Sept. 11, 1890</b>	
9. AGE (In years last birthday) <b>66 yrs.</b>		IF UNDER 1 YEAR: Months <b>66</b> Days <b>66</b> Hours <b>66</b> Min. <b>66</b>		IF UNDER 24 HRS. <b>66</b>			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Foreman (retired)</b>				10b. KIND OF BUSINESS OR INDUSTRY <b>Davidson Chem. Co.</b>		11. BIRTHPLACE (State or foreign country) <b>Baltimore, Md.</b>	
13. FATHER'S NAME <b>Jacob Knaus</b>				14. MOTHER'S MAIDEN NAME <b>Katie Round</b>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>no</b>				16. SOCIAL SECURITY NO. <b>--</b>		17. INFORMANT <b>Mrs. Mary Knaus,</b>	
				Address <b>Same As #2</b>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Uremia</b> <b>443X</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <b>Hypertensive Cardiovascular Disease</b> DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <b>3 mths.</b> <b>5 yrs.</b>							
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Hour a. m. <b>19</b> p. m. <b>19</b>				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
				20f. (City or town) (County) (State)			
21. I certify that I attended the deceased from <b>May 18, 1952</b> , to <b>May 18, 1957</b> , that I last saw the deceased alive on <b>May 18, 1957</b> , and that death occurred at <b>7:15 P. M.</b> from the causes and on the date stated above.							
ACTUAL SIGNATURE <b>C. Milton Smith</b>				ADDRESS (Street, city or town, state) <b>106 W. Maple Rd. Baltimore, Md.</b>			
DATE SIGNED <b>5/19/57</b>							
PHYSICIAN'S NAME (Type)							
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		22b. DATE THEREOF <b>May 21/57</b>		22c. NAME OF CEMETERY OR CREMATORY <b>Glen Haven Cem.</b>		22d. LOCATION (City, town, or county) (State) <b>Glen Burnie, Md.</b>	
23. FUNERAL DIRECTOR'S SIGNATURE <b>Richard L. Smith</b>				ADDRESS <b>Glen Burnie, Md.</b>		24a. REC'D BY REGISTRAR DATE <b>5/22/57</b>	
				24b. REGISTRAR'S SIGNATURE <b>Therese Joyce</b>			

# CERTIFICATE OF DEATH

BUREAU V. 4

MAY 22 1957

RECEIVED

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

## MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

4776

## CERTIFICATE OF DEATH

Reg. Dist. No.

04796

1. PLACE OF DEATH a. COUNTY <u>AA.</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE <u>Md.</u> b. COUNTY <u>AA.</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Annapolis</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>10 Annapolis Md.</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>105 Scott Drive</u>		d. STREET ADDRESS <u>105 Scott Drive</u> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <u>Joseph</u> Middle <u>D.</u> Last <u>Lagenby</u>		4. DATE OF DEATH Month <u>5</u> - Day <u>16</u> Year <u>1957</u>	
5. SEX <u>Male</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>4-20-1896</u>
9. AGE (In years last birthday) <u>61</u> yrs.		10. IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Real Estate - Insurance</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Real Estate</u>	
11. BIRTHPLACE (State or foreign country) <u>Baltimore Md.</u>		12. CITIZEN OF WHAT COUNTRY? <u>U. S. A.</u>	
13. FATHER'S NAME <u>Francis A. Lagenby</u>		14. MOTHER'S MAIDEN NAME <u>Sarah Deming</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <input type="checkbox"/>		16. SOCIAL SECURITY NO. <u>7</u>	
17. INFORMANT <u>Edith R. Lagenby</u>		Address <u>(2)</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>420.1</u> DUE TO <u>Coronary Thrombosis</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) _____ DUE TO _____ (c) _____ PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) _____ INTERVAL BETWEEN ONSET AND DEATH <u>1 hr</u>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <u>19</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>5-16-1957</u> to <u>5-17-1957</u> , that I last saw the deceased alive on <u>5-17-1957</u> , and that death occurred at <u>11:30</u> A.M. from the causes and on the date stated above. ADDRESS (Street, city or town, state) <u>65 HAW ST. ANNAPOLIS, MD.</u> DATE SIGNED <u>5-17-57</u>			
ACTUAL SIGNATURE <u>James R. Martin</u> M.D.		PHYSICIAN'S NAME (Type) <u>JAMES R. MARTIN</u>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Cremation</u>		22b. DATE THEREOF <u>5-18-57</u>	
22c. NAME OF CEMETERY OR CREMATORY <u>St. Lincoln</u>		22d. LOCATION (City, town, or county) (State) <u>Prince George's Md.</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>John M. Taylor</u> ADDRESS <u>Annapolis Md.</u>		24a. REC'D BY REGISTRAR DATE <u>5/20/57</u>	
24b. REGISTRAR'S SIGNATURE <u>J. J. Daniel</u>			

1957 22 14

**BUREAU A**



## INSTRUCTIONS

**1** TO ATTENDING PHYSICIAN OR HOSPITAL: The law requires that the death certificate be executed within 24 hours after death. The bottom copy may be retained by the hospital or attending physician.

**2** TO FUNERAL DIRECTOR: The law requires that the death certificate be filed with the registrar within 72 hours after death. After this certificate has been executed by the attending physician and completely filled out, by the funeral director, the third copy of this death certificate assembly should be detached for use as a burial transit permit.

VS 15C 1-55 10M

MARYLAND STATE DEPARTMENT OF HEALTH-BALTIMORE, 18

04797

## CERTIFICATE OF DEATH

Reg. Dist. No. 24

1. PLACE OF DEATH COUNTY <u>Anne Arundel</u> MARYLAND CITY (If outside corporate limits, write RURAL and give nearest town) <u>Glen Burnie</u> TOWN <u>Glen Burnie</u> HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>#103 Longwood Ave. Fern-Glen</u>				2. USUAL RESIDENCE (HOME) OF DECEASED STATE <u>Maryland</u> COUNTY <u>Anne Arundel</u> CITY (If outside corporate limits, write RURAL and give nearest town) <u>Glen Burnie</u> TOWN <u>Glen Burnie</u> STREET ADDRESS (If rural give location) <u>#103 Longwood Ave., Fernglen</u>			
3. NAME OF DECEASED (Type or Print) (First) (Middle) (Last) <u>ELSIE E. LYNCH</u>				4. DATE OF DEATH (Month) (Day) (Year) <u>May 10, 1957</u>			
5. SEX <u>Female</u>	6. COLOR OR RACE <u>White</u>	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) <u>Widow</u>	8. DATE OF BIRTH <u>Oct. 10, 1883</u>	9. AGE last birthday <u>73</u> yrs.	IF UNDER 1 YEAR Months Days Hours Min.		IF UNDER 24 HRS. Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housework (ret)</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Own Home</u>		11. BIRTHPLACE (State or foreign country) <u>Baltimore, Maryland</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>Henry Bush</u>				14. MOTHER'S MAIDEN NAME <u>Mary Henze</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unk.) <u>no</u> (If Yes, give war or dates of service)		16. SOCIAL SECURITY NO. <u>none</u>		17. INFORMANT & ADDRESS <u>Mrs. Gladys Castaneda Same As #2</u>			
18. MEDICAL CERTIFICATION						INTERVAL BETWEEN ONSET AND DEATH	
I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH 420.1 IMMEDIATE CAUSE (A) <u>Coronary Thrombosis</u>						2 day	
ANTECEDENT CAUSE(S) DUE TO DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST, DUE TO (B) <u>Hypertension, Cardiovascular disease</u>						5 years	
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH. (C)							
19a. DATE OF OPERATION		19b. MAJOR FINDINGS OF OPERATION				20. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)		21c. WHERE DID INJURY OCCUR? (City or town) (County) (State)			
21d. TIME OF INJURY (Month) (Day) (Year) (Hour) (Min.)		21a. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		21f. HOW DID INJURY OCCUR?			
22. I hereby certify that I attended the deceased from <u>Mar 17, 1957</u> , to <u>May 10, 1957</u> , that I last saw the deceased alive on <u>May 10, 1957</u> , and that death occurred at <u>5 P.</u> M, from the causes and on the date stated above.							
SIGNATURE <u>Henry Glusman</u>				ADDRESS (Street, city, town, state) <u>1687 Wiesters Ave. Baltimore, Md.</u>		DATE SIGNED	
23. BURIAL, CREMATION, REMOVAL (SPECIFY) <u>Burial</u>		DATE THEREOF <u>May 14/57</u>		NAME OF CEMETERY OR CREMATORY <u>Woodlawn Cem.</u>		LOCATION (City, town, or county) (State) <u>Baltimore, Md.</u>	
24. REC'D BY REGISTRAR <u>5/15/57</u>		REGISTRAR'S SIGNATURE <u>Louis J. De Alba</u>		25. FUNERAL DIRECTOR'S SIGNATURE <u>[Signature]</u>		ADDRESS <u>Glen Burnie, Md.</u>	

# CERTIFICATE OF DEATH

Reg. Dist. No.

DATE WHEN DEATH OCCURRED

NAME OF DECEASED

AGE

SEX

DATE

TIME

PLACE

CAUSE

PLACE

DATE

TIME

PLACE

CAUSE

NAME OF DECEASED

AGE

SEX

NAME OF DECEASED

NAME OF DECEASED

NAME OF DECEASED

AGE

SEX

NAME OF DECEASED

NAME OF DECEASED

BUREAU V. E.

MAY 15 1957

RECEIVED

John H. Tamm, M.D.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please enclose the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.  
TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the registrar prior to funeral, cremation, or removal.

1  
MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

4816

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

Items 8.9:G216 5-28-57L Item 20 Film 216 6-5-57 am

Reg. Dist. No. 04798/3

1. PLACE OF DEATH a. COUNTY <u>Anne Arundel</u> MARYLAND			2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Md.</u> b. COUNTY <u>Balto.</u>		
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)			c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)		
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>Crain Highway</u>			e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		
3. NAME OF DECEASED (Type or print) First <u>Salvatore</u> Middle <u>J</u> Last <u>Maggio</u> JR			4. DATE OF DEATH Month <u>May</u> Day <u>24</u> Year <u>1957</u>		
5. SEX <u>M</u>		6. COLOR OR RACE <u>W</u>		7. MARRIAGE <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	
8. DATE OF BIRTH <u>6-21-24</u>		9. AGE (In years last birthday) <u>32</u> yrs.		10. IF UNDER 1 YEAR Months <u>24</u> Days <u>24</u> Hours <u>19</u> Min.	
11. BIRTHPLACE (State or foreign country) <u>Dec. 24, 1898</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>			
13. FATHER'S NAME <u>Salvatore J. Maggio Sr.</u>			14. MOTHER'S MAIDEN NAME <u>Concetta Maranto</u>		
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>Yes</u>			16. SOCIAL SECURITY NO. <u>W.W.11</u>		
17. INFORMANT <u>Mrs. Marie Audrey Maggio</u>			Address <u>650 Orpington Rd</u>		
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>3rd Degree burns 100% of Body</u> 816x DUE TO Conditions, if any, which gave rise to immediate cause (b) (c), stating the underlying cause lost. DUE TO (c)					
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)					
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>					
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.			20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <u>Burned in auto-truck collision</u>		
20c. TIME OF INJURY Month, Day, Year Hour <u>12:32</u> p. m. <u>5/24/57</u> 19			20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input checked="" type="checkbox"/>		
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <u>street</u>			20f. (City or town) (County) (State) <u>Millersville Anne Arundel Md.</u>		
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and find that death resulted from: Natural causes <input type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined cause <input type="checkbox"/> .					
ACTUAL SIGNATURE <u>William V. Gault</u>			M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/>		
EXAMINER'S NAME (Type) <u>Witzke Funeral Directors</u>			ASSISTANT MEDICAL EXAMINER <input checked="" type="checkbox"/> <u>5/25/57</u>		
DEPUTY MEDICAL EXAMINER <input type="checkbox"/>			DATE SIGNED		
22a. BURIAL, CREMATION, or other disposition (Specify) <u>Burial</u>		22b. DATE THEREOF <u>May 27/57</u>		22c. NAME OF CEMETERY OR CREMATORY <u>New Cathedral</u>	
22d. LOCATION (City, town, or county) (State) <u>Baltimore, Md.</u>					
23. FUNERAL DIRECTOR'S SIGNATURE <u>Witzke Funeral Directors, 4101 Edmondson</u>			24a. REC'D BY REGISTRAR <u>May 27 1957</u>		
24b. REGISTRAR'S SIGNATURE <u>L. J. Adkins</u>					

RECEIVED

MAY 27 1957

BUREAU V. S.

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

## MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

## 4817 CERTIFICATE OF DEATH

04799

Reg. Dist. No. 27

1. PLACE OF DEATH a. COUNTY <u>Anne Arundel</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Anne Arundel</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Fort George G. Meade</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>X2 Ft George G. Meade</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>U. S. Army Hospital</u>		d. STREET ADDRESS <u>1 Quarters # 4316</u>	
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First <u>ANN</u> Middle <u>PEYTON</u> Last <u>MAGRUDER</u>		4. DATE OF DEATH Month <u>May</u> Day <u>30</u> Year <u>1957</u>	
5. SEX <u>Female</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>8 May 1888</u>
9. AGE (In years last birthday) <u>69</u> yrs.		IF UNDER 1 YEAR Months _____ Days _____ Hours _____ Min. _____	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Own home</u>	
11. BIRTHPLACE (State or foreign country) <u>Mississippi</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13. FATHER'S NAME <u>Harry Peyton</u>		14. MOTHER'S MAIDEN NAME <u>Margaret Alexander</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. <u>577-50-7785</u>	
17. INFORMANT <u>Col Conway</u>		Address <u>Hq 2 U.S. Army Ft Meade, Md</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Carcinomatosis, originating from left breast</u> <u>170x</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) _____ DUE TO (c) _____		INTERVAL BETWEEN ONSET AND DEATH <u>3 years</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <u>19</u>		20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> of work of work	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>2/1</u> , 19 <u>57</u> , to <u>5/30</u> , 19 <u>57</u> , that I last saw the deceased alive on <u>5/30</u> , 19 <u>57</u> , and that death occurred at <u>11:55 PM</u> , from the causes and on the date stated above. ADDRESS (Street, city or town, state) <u>USAH, Ft George G. Meade, Md.</u> DATE SIGNED <u>31 May 57</u>			
ACTUAL SIGNATURE <u>Robert T. Jensen</u>		PHYSICIAN'S NAME (Type) <u>ROBERT T. JENSEN, LT COL, MC</u>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>3 June 57</u>	
22c. NAME OF CEMETERY OR CREMATORY <u>Arlington, National</u>		22d. LOCATION (City, town, or county) (State) <u>Arlington, VA</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>WARREN E. PUMPHREY</u>		24a. REC'D BY REGISTRAR <u>31 May 57</u>	
ADDRESS <u>8434 Georgia Ave, Silver Spring, Md</u>		24b. REGISTRAR'S SIGNATURE <u>W. L. Saylor, 1st Lt, MSC</u>	



BUREAU V. S.

JUN 5 1957

RECEIVED



4777

CERTIFICATE OF DEATH

Reg. Dist. No. 21

1. PLACE OF DEATH o. COUNTY <u>Anne Arundel</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution residence before admission) o. STATE <u>Maryland</u> b. COUNTY <u>C.C.</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Annapolis</u>				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Annapolis</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>1987 Street St. Ept.</u>				d. STREET ADDRESS <u>1987 Street St. Ept.</u>			
3. NAME OF DECEASED (Type or print) First <u>Joseph</u> Middle <u>Matthews</u> Last <u>Matthews</u>				4. DATE OF DEATH Month <u>5</u> Day <u>10</u> Year <u>1957</u>			
5. SEX <u>Male</u>		6. COLOR OR RACE <u>Ch.</u>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>9-8-1886</u>	
9. AGE (In years last birthday) <u>70</u> yrs.		IF UNDER 1 YEAR Months <u>10</u> Days <u>10</u> Hours <u>10</u> Min. <u>10</u>		IF UNDER 24 HRS. Months <u>10</u> Days <u>10</u> Hours <u>10</u> Min. <u>10</u>		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Retired</u>	
11. PLACE OF BIRTH (State or foreign country) <u>U.S. Naval Acad.</u>		12. CITIZEN OF WHOM COUNTRY? <u>U.S.A.</u>		13. FATHER'S NAME <u>Edward Matthews</u>		14. MOTHER'S MAIDEN NAME <u>Hennetta Davis</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes or unknown) <u>Yes</u> (If yes, give year or dates of service) <u>WW I</u>		16. SOCIAL SECURITY NO. <u>-</u>		17. INFORMANT <u>Margaret Matthews Anna. Md.</u>		Address <u>Anna. Md.</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Cerebral Hemorrhage.</u> <u>331X</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Hypertensive-Vascular Disease</u> DUE TO (c) <u>1 yr.</u>						INTERVAL BETWEEN ONSET AND DEATH <u>2 hr.</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <u>19</u>				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>			
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)				20f. (City or town) (County) (State)			
21. I certify that I attended the deceased from <u>8/12/57</u> , 19 <u>57</u> , to <u>5/10/57</u> , 19 <u>57</u> , that I last saw the deceased alive on <u>5/10</u> , 19 <u>57</u> , and that death occurred at <u>10</u> P. M., from the causes and on the date stated above.							
ACTUAL SIGNATURE <u>Theodore H. Johnson</u> M.D.				DATE SIGNED <u>5/13/57</u>			
PHYSICIAN'S NAME (Type) <u>Dr. THEODORE H. JOHNSON</u>				ADDRESS <u>Annapolis, Md.</u>			
22a. BURIAL, CREMATION, OR REMOVAL (Specify)		22b. DATE THEREOF		22c. NAME OF CEMETERY OR CREMATORY		22d. LOCATION (City, town, or county) (State)	
<u>Burial</u>		<u>5-14-57</u>		<u>Annapolis</u>		<u>Annapolis, Md.</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>William Reese, Jr.</u>				ADDRESS <u>Annapolis, Md.</u>		24a. REC'D BY REGISTRAR DATE <u>5/13/57</u>	
				24b. REGISTRAR'S SIGNATURE <u>Wm. J. French</u>			

BUREAU OF

1957 14

RECEIVED

• 12-11-2012

4778

## CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <i>Anne Arundel</i> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <i>New York</i> b. COUNTY <i>New York</i>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Annapolis</i>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>New York</i> 69X-3	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <i>Anne Arundel General</i>		d. STREET ADDRESS <i>84-47 118th St.</i>	
3. NAME OF DECEASED (Type or print) First <i>Emma</i> Middle <i>S.</i> Last <i>Muller</i>		4. DATE OF DEATH Month <i>May</i> Day <i>17</i> Year <i>1957</i>	
5. SEX <i>Female</i>	6. COLOR OR RACE <i>White</i>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <i>7-19-1885</i>
9. AGE (In years last birthday) <i>71</i> yrs.		IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>Housewife</i>		10b. KIND OF BUSINESS OR INDUSTRY <i>Own Home</i>	
11. BIRTHPLACE (State or foreign country) <i>Pennsylvania</i>		12. CITIZEN OF WHAT COUNTRY? <i>USA</i>	
13. FATHER'S NAME <i>Joseph H. Pryor</i>		14. MOTHER'S MAIDEN NAME <i>Agnes Farrel</i>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <i>No</i>		16. SOCIAL SECURITY NO. (If yes, give war or dates of service) <i>—</i>	
17. INFORMANT <i>Frederick A. Muller</i>		Address <i># 2</i>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>420.0 arteriosclerotic heart disease</i> DUE TO (b) <i>acute cardiac failure</i> DUE TO (c) <i>—</i> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <i>450.0 gen. arteriosclerosis</i>			
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. p. m. <i>19</i>	20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I attended the deceased from <i>5-19</i> , 19 <i>57</i> , to <i>5-17</i> , 19 <i>57</i> ; that I last saw the deceased alive on <i>5-17</i> , 19 <i>57</i> , and that death occurred at <i>2:11 PM</i> , from the causes and on the date stated above. ADDRESS (Street, city or town, state) <i>45 Franklin St. Annapolis, Md.</i> DATE SIGNED <i>—</i>			
ACTUAL SIGNATURE <i>Edith Rodler</i>		M.D. <i>45 Franklin St. Annapolis, Md.</i>	
PHYSICIAN'S NAME (Type) <i>EDITH RODLER M.D.</i>		<i>45 FRANKLIN ST. ANNAPOLIS</i>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <i>—</i>	22b. DATE THEREOF <i>MAY 17 1957</i>	22c. NAME OF CEMETERY OR CREMATORY	22d. LOCATION (City, town, or county) (State) <i>NEW YORK CITY N.Y.</i>
23. FUNERAL DIRECTOR'S SIGNATURE <i>JOHN M. TAYLOR, SON</i>		ADDRESS <i>ANNAPOLIS, MD.</i>	
24a. REC'D BY REGISTRAR <i>—</i>		24b. REGISTRAR'S SIGNATURE <i>—</i>	

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 1 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be attached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

RECEIVED  
1957

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

CERTIFICATE OF DEATH

Reg. Dist. No. 27

04802

4818

1. PLACE OF DEATH a. COUNTY <u>Anne Arundel</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>California</u> b. COUNTY <u>Los Angeles</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>FT. GEO. G. MEADE</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Los Angeles</u> 43X-3 ✓	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>U.S. ARMY HOSPITAL</u>		d. STREET ADDRESS <u>5426 West Adam Blvd.</u>	
3. NAME OF DECEASED (Type or print) First <u>INFANT</u> Middle <u>MALE</u> Last <u>OLIVER</u>		4. DATE OF DEATH Month <u>May</u> Day <u>19</u> Year <u>1957</u>	
5. SEX <u>MALE</u>	6. COLOR OR RACE <u>NEGRO</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>18 MAY 57</u>
9. AGE (In years last birthday) yrs. <u>8</u> Months <u>51</u> Days <u>51</u> Hours <u>51</u> Min. <u>51</u>		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>None</u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>None</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>None</u>	
11. BIRTHPLACE (State or foreign country) <u>MARYLAND</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>Lawrence Oliver</u>		14. MOTHER'S MAIDEN NAME <u>Bonnie Fuller</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>NO</u>		16. SOCIAL SECURITY NO. <u>--</u>	
17. INFORMANT <u>Father, Rt #1, Box 281 Jessup, Maryland</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Immaturity (Prematurity)</u> <u>776 X</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) DUE TO (c)		INTERVAL BETWEEN ONSET AND DEATH <u>8 hrs 51 min</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <u>19</u>		20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> of work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>18 May</u> , 19 <u>57</u> , to <u>19 May</u> , 19 <u>57</u> , that I last saw the deceased alive on <u>19 May</u> , 19 <u>57</u> , and that death occurred at <u>0031 A.M.</u> from the causes and on the date stated above.			
ACTUAL SIGNATURE <u>James G. White</u>		ADDRESS (Street, city or town, state) <u>USAH, Fort George G. Meade, Maryland</u>	
PHYSICIAN'S NAME (Type) <u>JAMES G. WHITE, Capt., MC.</u>		DATE SIGNED <u>19 May 57</u>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>5/22/1957</u>	
22c. NAME OF CEMETERY OR CREMATORY <u>Baltimore National</u>		22d. LOCATION (City, town, or county) (State) <u>Baltimore, Md.</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>ARLINGTON S. PHILLIPS, Inc., Baltimore, Md.</u>		24a. REC'D BY REGISTRAR <u>20 May 57</u>	
24b. REGISTRAR'S SIGNATURE <u>W.L. SAYLOR, 1st Lt, MSC</u>			

2050201XV0



CERTIFICATE OF DEATH

1. NAME OF DECEASED JAMES EARL RAY		2. SEX Male		3. AGE 35	
4. DATE OF DEATH April 4, 1968		5. TIME OF DEATH 2:01 PM		6. PLACE OF DEATH Room 308, Airport Hotel, Memphis, Tennessee	
7. CAUSE OF DEATH Shot		8. MANNER OF DEATH Suicide		9. PLACE OF BIRTH Jackson, Mississippi	
10. OCCUPATION Attorney		11. EDUCATION High School		12. RELIGION Methodist	
13. MARITAL STATUS Single		14. SOCIAL SECURITY NUMBER [REDACTED]		15. SIGNATURE OF DECEASED [REDACTED]	
16. SIGNATURE OF WITNESSES [REDACTED]		17. SIGNATURE OF PHYSICIAN [REDACTED]		18. SIGNATURE OF CORONER [REDACTED]	
19. SIGNATURE OF COUNTY CLERK [REDACTED]		20. SIGNATURE OF STATE CLERK [REDACTED]		21. SIGNATURE OF DEPARTMENT CLERK [REDACTED]	

BUREAU V. M.  
APR 23 1968

RECEIVED



## MEDICAL EXAMINER'S CERTIFICATE OF DEATH

Reg. Dist. No. 21

4779

1. PLACE OF DEATH a. COUNTY <b>Anne Arundel</b> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Anne Arundel</b>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Annapolis</b>				c. LENGTH OF STAY IN 1b			
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <b>101 N. Glenn Ave.</b>				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First Middle Last <b>RAYMOND F PRICE</b>				4. DATE OF DEATH Month Day Year <b>MAY 31 19 57</b>			
5. SEX <b>Male</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>Sept 24, 1909</b>		9. AGE (In years last birthday) <b>47 yrs.</b>	IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>US Navy Retired</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>US Navy</b>		11. BIRTHPLACE (State or foreign country) <b>Nebraska</b>		12. CITIZEN OF WHAT COUNTRY? <b>USA</b>	
13. FATHER'S NAME <b>George F. Price</b>				14. MOTHER'S MAIDEN NAME <b>Elva Binegar</b>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>Yes WW II</b>		16. SOCIAL SECURITY NO. <b>217-38-0074</b>		17. INFORMANT Address <b>Mrs Anna Mary Price Wife same as # 2</b>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Suicide by carbon monoxide</b> DUE TO (b) <b>973.1</b> Conditions, if any, which gave rise to immediate cause (c), stating the underlying cause lost. DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <b>Auto exhaust piped into closed car in garage of home</b> INTERVAL BETWEEN ONSET AND DEATH <b>Sudden</b>							
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
20a. EXTERNAL CAUSE WAS PRIMARY <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <b>Auto exhaust piped into closed car in garage of home</b>			
20c. TIME OF INJURY Month, Day, Year <b>xx May 31 1957</b> Hour o. m. <b>xx</b>				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input checked="" type="checkbox"/> <b>Gargge</b>			
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <b>Annapolis, Anne Arundel, Md.</b>				20f. (City or town) (County) (State)			
21. I certify that I took charge of the remains described above, held on Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and find that death resulted from: Natural causes <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input checked="" type="checkbox"/> Homicide <input type="checkbox"/> Undetermined cause <input type="checkbox"/> .							
ACTUAL SIGNATURE <b>Elmer G. Linhardt</b>				M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>			
EXAMINER'S NAME (Type) <b>Elmer G. Linhardt</b>				DATE SIGNED <b>May 31, 1957</b>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		22b. DATE THEREOF <b>June 4, 1957</b>		22c. NAME OF CEMETERY OR CREMATORY <b>Annapolis National Cemetery</b>		22d. LOCATION (City, town, or county) (State) <b>Annapolis, Maryland</b>	
23. FUNERAL DIRECTOR'S SIGNATURE <b>Hopping Funeral Home</b>				24a. REC'D BY REGISTRAR <b>JUN 3 1957</b>			
ADDRESS <b>Annapolis, Md.</b>				24b. REGISTRAR'S SIGNATURE <b>Wm. J. French</b>			

MEDICAL CERTIFICATION

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.  
TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.

MARYLAND STATE DEPARTMENT OF HEALTH - BIRTH-DEATH-19  
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

Form with multiple sections for medical examination, including fields for name, age, sex, race, occupation, cause of death, and place of death. The form is partially filled out with handwritten information.

RECEIVED  
JUN 3 1957  
BUREAU V. S.

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

Item 9 FilmG216 6-10-57 et

CERTIFICATE OF DEATH

04804

4780

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>ANNE ARUNDEL</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>MARYLAND</u> b. COUNTY <u>AAC</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>ANNAPOLIS</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>ARNOLD AAC, Md.</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>63 ANNE ARUNDEL General</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <u>NOAH</u> Middle <u>Jacob</u> Last <u>Pulley</u>		4. DATE OF DEATH Month <u>MAY</u> Day <u>31</u> Year <u>1957</u>	
5. SEX <u>M</u>	6. COLOR OR RACE <u>C</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>MARCH</u>
9. AGE (In years last birthday) <u>65</u> yrs.		10. IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Laborer</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>NONE</u>	
11. BIRTHPLACE (State or foreign country) <u>ARNOLD</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>Jacob Pulley</u>		14. MOTHER'S MAIDEN NAME <u>MAMIE TURNER</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>No</u>		16. SOCIAL SECURITY NO. <u>213-180-236</u>	
17. INFORMANT <u>SARAH JANE Pulley</u>		Address <u>ARNOLD Md</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>cerebral hemorrhage</u> <u>443X</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>hypertensive cardiovascular disease, 2 Yr.</u> DUE TO (c) <u>Ren. Arteriosclerosis</u>		INTERVAL BETWEEN ONSET AND DEATH	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>331X</u>		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>5-28, 1957</u> to <u>5-31, 1957</u> , that I last saw the deceased alive on <u>5-31</u> 19 <u>57</u> , and that death occurred at <u>4:15</u> M, from the causes and on the date stated above.		ADDRESS (Street, city or town, state) DATE SIGNED	
ACTUAL SIGNATURE <u>Edith R. Dwyer</u> M.D. <u>45 Franklin St. Annapolis, Md.</u>		PHYSICIAN'S NAME (Type) <u>EDITH R. DWYER</u> <u>45 FRANKLIN ST. ANNAPOLIS</u>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>✓</u>		22b. DATE THEREOF <u>✓</u>	
22c. NAME OF CEMETERY OR CREMATORY		22d. LOCATION (City, town, or county) (State)	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Edith R. Dwyer</u> ADDRESS <u>43 NORTHWEST ST. CITY</u>		24a. REC'D BY REGISTRAR DATE <u>6/3/57</u>	
24b. REGISTRAR'S SIGNATURE			

CERTIFICATE OF DEATH

5790

MARYLAND STATE DEPARTMENT OF HEALTH - BALTIMORE 18

1. NAME OF DECEASED JAMES EARL RAY		2. SEX Male		3. AGE 35	
4. DATE OF DEATH April 4, 1968		5. TIME OF DEATH 10:00 AM		6. PLACE OF DEATH Memphis, Tennessee	
7. CAUSE OF DEATH Suicide		8. MANNER OF DEATH Homicide		9. PLACE OF BIRTH Jackson, Mississippi	
10. DATE OF BIRTH March 24, 1933		11. TIME OF BIRTH 10:00 AM		12. PLACE OF BIRTH Jackson, Mississippi	
13. NAME OF FATHER James Earl Ray		14. NAME OF MOTHER Jane Bernice Ray		15. NAME OF SPOUSE None	
16. NAME OF CHILDREN None		17. NAME OF SIBLINGS None		18. NAME OF OTHER RELATIVES None	
19. NAME OF DECEASED'S DOCTOR None		20. NAME OF DECEASED'S ATTORNEY None		21. NAME OF DECEASED'S MINISTER None	
22. NAME OF DECEASED'S EMPLOYER None		23. NAME OF DECEASED'S OCCUPATION None		24. NAME OF DECEASED'S RELIGION None	
25. NAME OF DECEASED'S RACE White		26. NAME OF DECEASED'S ETHNICITY None		27. NAME OF DECEASED'S NATIONALITY American	
28. NAME OF DECEASED'S CITIZENSHIP None		29. NAME OF DECEASED'S RESIDENCE None		30. NAME OF DECEASED'S SOCIAL SECURITY NUMBER None	
31. NAME OF DECEASED'S MARITAL STATUS None		32. NAME OF DECEASED'S EDUCATION None		33. NAME OF DECEASED'S RELIGION None	
34. NAME OF DECEASED'S RACE White		35. NAME OF DECEASED'S ETHNICITY None		36. NAME OF DECEASED'S NATIONALITY American	
37. NAME OF DECEASED'S CITIZENSHIP None		38. NAME OF DECEASED'S RESIDENCE None		39. NAME OF DECEASED'S SOCIAL SECURITY NUMBER None	
40. NAME OF DECEASED'S MARITAL STATUS None		41. NAME OF DECEASED'S EDUCATION None		42. NAME OF DECEASED'S RELIGION None	
43. NAME OF DECEASED'S RACE White		44. NAME OF DECEASED'S ETHNICITY None		45. NAME OF DECEASED'S NATIONALITY American	
46. NAME OF DECEASED'S CITIZENSHIP None		47. NAME OF DECEASED'S RESIDENCE None		48. NAME OF DECEASED'S SOCIAL SECURITY NUMBER None	
49. NAME OF DECEASED'S MARITAL STATUS None		50. NAME OF DECEASED'S EDUCATION None		51. NAME OF DECEASED'S RELIGION None	
52. NAME OF DECEASED'S RACE White		53. NAME OF DECEASED'S ETHNICITY None		54. NAME OF DECEASED'S NATIONALITY American	
55. NAME OF DECEASED'S CITIZENSHIP None		56. NAME OF DECEASED'S RESIDENCE None		57. NAME OF DECEASED'S SOCIAL SECURITY NUMBER None	
58. NAME OF DECEASED'S MARITAL STATUS None		59. NAME OF DECEASED'S EDUCATION None		60. NAME OF DECEASED'S RELIGION None	
61. NAME OF DECEASED'S RACE White		62. NAME OF DECEASED'S ETHNICITY None		63. NAME OF DECEASED'S NATIONALITY American	
64. NAME OF DECEASED'S CITIZENSHIP None		65. NAME OF DECEASED'S RESIDENCE None		66. NAME OF DECEASED'S SOCIAL SECURITY NUMBER None	
67. NAME OF DECEASED'S MARITAL STATUS None		68. NAME OF DECEASED'S EDUCATION None		69. NAME OF DECEASED'S RELIGION None	
70. NAME OF DECEASED'S RACE White		71. NAME OF DECEASED'S ETHNICITY None		72. NAME OF DECEASED'S NATIONALITY American	
73. NAME OF DECEASED'S CITIZENSHIP None		74. NAME OF DECEASED'S RESIDENCE None		75. NAME OF DECEASED'S SOCIAL SECURITY NUMBER None	
76. NAME OF DECEASED'S MARITAL STATUS None		77. NAME OF DECEASED'S EDUCATION None		78. NAME OF DECEASED'S RELIGION None	
79. NAME OF DECEASED'S RACE White		80. NAME OF DECEASED'S ETHNICITY None		81. NAME OF DECEASED'S NATIONALITY American	
82. NAME OF DECEASED'S CITIZENSHIP None		83. NAME OF DECEASED'S RESIDENCE None		84. NAME OF DECEASED'S SOCIAL SECURITY NUMBER None	
85. NAME OF DECEASED'S MARITAL STATUS None		86. NAME OF DECEASED'S EDUCATION None		87. NAME OF DECEASED'S RELIGION None	
88. NAME OF DECEASED'S RACE White		89. NAME OF DECEASED'S ETHNICITY None		90. NAME OF DECEASED'S NATIONALITY American	
91. NAME OF DECEASED'S CITIZENSHIP None		92. NAME OF DECEASED'S RESIDENCE None		93. NAME OF DECEASED'S SOCIAL SECURITY NUMBER None	
94. NAME OF DECEASED'S MARITAL STATUS None		95. NAME OF DECEASED'S EDUCATION None		96. NAME OF DECEASED'S RELIGION None	
97. NAME OF DECEASED'S RACE White		98. NAME OF DECEASED'S ETHNICITY None		99. NAME OF DECEASED'S NATIONALITY American	
100. NAME OF DECEASED'S CITIZENSHIP None		101. NAME OF DECEASED'S RESIDENCE None		102. NAME OF DECEASED'S SOCIAL SECURITY NUMBER None	

BUREAU V. 1

JUN 4 1968

RECEIVED

# MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

## MEDICAL EXAMINER'S CERTIFICATE OF DEATH

Reg. Dist. No.

04895

4781

1. PLACE OF DEATH a. COUNTY <u>Anne Arundel</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>C.C.</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Annapolis</u>		c. LENGTH OF STAY IN 1b <u>10</u>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>35 Larkin St.</u>		d. STREET ADDRESS <u>38 Larkin St.</u>	
3. NAME OF DECEASED (Type or print) First <u>Bertha</u> Middle <u>Randall</u> Last <u></u>		4. DATE OF DEATH Month <u>5</u> Day <u>12</u> Year <u>1957</u>	
5. SEX <u>Female</u>	6. COLOR OR RACE <u>Col</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>12-8-1912</u>
9. AGE (In years last birthday) <u>44</u> yrs.		IF UNDER 1 YEAR Months <u></u> Days <u></u> Hours <u></u> Min. <u></u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>		10b. KIND OF BUSINESS OR INDUSTRY <u></u>	
11. BIRTHPLACE (State or foreign country) <u>Tampa, Fla.</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>Unknown</u>		14. MOTHER'S MAIDEN NAME <u>Sallie Storks</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>1701</u>		16. SOCIAL SECURITY NO. <u></u>	
17. INFORMANT <u>James Randall</u> Address <u>Annapolis, Md.</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>myocardial failure</u> DUE TO (b) <u>sudden</u> Conditions, if any, which gave rise to immediate cause (c), stating the underlying cause last. (c) <u></u>			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u></u>			
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>			
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input type="checkbox"/> Inquiry <input type="checkbox"/> and find that death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined cause <input type="checkbox"/> .			
ACTUAL SIGNATURE <u>[Signature]</u>		M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/>	
EXAMINER'S NAME (Type) <u>E. L. N. H. A. D. T.</u>		ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>	
		DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>	
22a. BURIAL, CREMATION, REMOVAL (Specify)	22b. DATE THEREOF <u>5-17-57</u>	22c. NAME OF CEMETERY OR CREMATORY <u>Brewer Hill</u>	22d. LOCATION (City, town, or county) (State) <u>Annapolis, Md.</u>
23. FUNERAL DIRECTOR'S SIGNATURE <u>William Reese</u>		24. REC'D BY REGISTRAR <u>Dr. Wm. J. French</u>	
ADDRESS <u></u>		DATE <u>5/15/57</u>	

MEDICAL CERTIFICATION

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with farm PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the registrar prior to burial, cremation or removal.



MARYLAND STATE DEPARTMENT OF HEALTH - BALTIMORE 18  
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

BUREAU V. 44

MAY 15 1957

RECEIVED

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

4819

CERTIFICATE OF DEATH

04806

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <i>A.A. Crooksville</i> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <i>Maryland</i> b. COUNTY	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Baltimore Md 3101.4</i>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <i>Crooksville State Hosp.</i>		d. STREET ADDRESS <i>538 N. Carrollton Ave</i>	
3. NAME OF DECEASED (Type or print) <i>Hamley First Middle Last Richardson</i>		4. DATE OF DEATH <i>May 17</i> Year <i>1957</i>	
5. SEX <i>Male</i>	6. COLOR OR RACE <i>N.</i>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <i>11.18.94</i>
9. AGE (In years last birthday) <i>62</i> yrs.		IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>Laborer</i>		10b. KIND OF BUSINESS OR INDUSTRY <i>Meat Packer</i>	
11. BIRTHPLACE (State or foreign country) <i>Maryland</i>		12. CITIZEN OF WHAT COUNTRY? <i>U.S. A</i>	
13. FATHER'S NAME <i>Hamley Richardson</i>		14. MOTHER'S MAIDEN NAME <i>Alberta</i>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <i>Army #1</i>		16. SOCIAL SECURITY NO. <i>215-09-9737</i>	
17. INFORMANT <i>Edith Richardson</i>		Address <i>538 N. Carrollton Ave Balt.</i>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>Cerebral Hemorrhage</i> <i>331x</i> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			INTERVAL BETWEEN ONSET AND DEATH
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)
20c. TIME OF INJURY Month, Day, Year Hour o. ft. p. m. <i>19</i>		20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work at work	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <i>4-18-57</i> to <i>5-17-57</i> , that I last saw the deceased alive on <i>5-17-57</i> , and that death occurred at <i>8:30 P.M.</i> from the causes and on the date stated above.			
ACTUAL SIGNATURE <i>[Signature]</i>		M.D. _____	
PHYSICIAN'S NAME (Type) _____		ADDRESS (Street, city or town, state) _____	
22a. BURIAL, CREMATION, REMOVAL (Specify) <i>Burial</i>		22b. DATE THEREOF <i>5/22/57</i>	
22c. NAME OF CEMETERY OR CREMATORY <i>Baltimore Natl Cem.</i>		22d. LOCATION (City, town, or county) (State) <i>Baltimore Md</i>	
23. FUNERAL DIRECTOR'S SIGNATURE <i>Chas. G. Cooper</i>		ADDRESS <i>512 Broad St</i>	
24a. REC'D BY REGISTRAR <i>[Signature]</i>		24b. REGISTRAR'S SIGNATURE <i>[Signature]</i>	



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

## MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

4782

## CERTIFICATE OF DEATH

Reg. Dist. No. 21

04807

1. PLACE OF DEATH a. COUNTY <b>Anne Arundel</b> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) b. COUNTY <b>Anne Arundel</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Annapolis</b>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Annapolis</b>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>Anne Arundel General Hospital</b>		d. STREET ADDRESS <b>130 Severn Ave.</b>	
3. NAME OF DECEASED (Type or print) First <b>RUTH</b> Middle <b>RILEY</b> Last		4. DATE OF DEATH Month <b>MAY</b> Day <b>6</b> Year <b>19 57</b>	
5. SEX <b>Female</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>July 21, 1889</b>
9. AGE (In years last birthday) <b>67</b> yrs.		IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>House wife</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>own home</b>	
11. BIRTHPLACE (State or foreign country) <b>Maryland</b>		12. CITIZEN OF WHAT COUNTRY? <b>USA</b>	
13. FATHER'S NAME <b>Richard Moreland</b>		14. MOTHER'S MAIDEN NAME <b>Mary E. Crosby</b>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>(If yes, give war or dates of service)</b>		16. SOCIAL SECURITY NO. <b>---</b>	
17. INFORMANT <b>Mrs John W. Riley- husband- same as # 2</b>		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Cancer of Parathyroid &amp; Metastases</b> DUE TO (b) _____ DUE TO (c) _____ Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) _____ INTERVAL BETWEEN ONSET AND DEATH <b>3 yrs.</b>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)		20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <b>19</b>	
20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town)		(County) (State)	
21. I certify that I attended the deceased from <b>Jan 15, 1954</b> to <b>May 6, 1957</b> , that I last saw the deceased alive on <b>May 6, 1957</b> and that death occurred at <b>11:38</b> M. from the causes and on the date stated above. ADDRESS (Street, city or town, state) <b>Annapolis, Md 57815</b> DATE SIGNED <b>5/8/57</b>			
ACTUAL SIGNATURE <b>Maurice F. Klawans</b> M.D.			
PHYSICIAN'S NAME (Type) <b>Maurice F. Klawans MD</b> <b>31 Southgate Ave Annapolis, Md.</b>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		22b. DATE THEREOF <b>May 9, 1957</b>	
22c. NAME OF CEMETERY OR CREMATORY <b>Cedar Bluff Cemetery</b>		22d. LOCATION (City, town, or county) (State) <b>Annapolis, Maryland</b>	
23. FUNERAL DIRECTOR'S SIGNATURE <b>HOPPING FUNERAL HOME</b>		24a. REC'D BY REGISTRAR <b>MAY 10 1957</b>	
ADDRESS <b>Annapolis, Md.</b>		24b. REGISTRAR'S SIGNATURE <b>John J. Lundy</b>	

[S]

**BUREAU V. S.**

MAY 10 1957

RECEIVED



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

## MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

04808

4783

## CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>AA.</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>MD.</u> b. COUNTY <u>AA.</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>ANNAPOLIS</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>X2 DEALE MD</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>HOMewood CONVALESCENT HOME</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <u>KATHARINE</u> Middle <u>L.</u> Last <u>ROCKHOLD</u>		4. DATE OF DEATH Month <u>MAY</u> Day <u>29</u> Year <u>1957</u>	
5. SEX <u>FEMALE</u>	6. COLOR OR RACE <u>WHITE</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>MAY 14, 1868</u>
9. AGE (In years last birthday) <u>89</u> yrs.		IF UNDER 1 YEAR: Months <u>  </u> Days <u>  </u> Hours <u>  </u> Min. <u>  </u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>SCHOOL INSTRUCTOR</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>RET.</u>	
11. BIRTHPLACE (State or foreign country) <u>AA. Co. MD.</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>ELIJAH L. ROCKHOLD</u>		14. MOTHER'S MAIDEN NAME <u>SUSAN P. BALDWIN</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>no</u>		16. SOCIAL SECURITY NO. <u>—</u>	
17. INFORMANT <u>Wm F Deale</u>		Address <u>Deale Md</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Acute myocardial insufficiency</u> <u>443X</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Hypertensive Cardiovascular disease</u> DUE TO (c) <u>  </u>		INTERVAL BETWEEN ONSET AND DEATH <u>Sudden</u> <u>5 years</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>422.2</u>		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. p. m. <u>  </u> <u>  </u> <u>19</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>Jan</u> , 19 <u>56</u> to <u>May</u> , 19 <u>57</u> , that I last saw the deceased alive on <u>29 May</u> , 19 <u>57</u> , and that death occurred at <u>5:30 AM</u> , from the causes and on the date stated above.			
ACTUAL SIGNATURE <u>F.D. Hendricks</u>		DATE SIGNED <u>5/30/57</u>	
PHYSICIAN'S NAME (Type) <u>F.D. Hendricks</u>		ADDRESS (Street, city or town, state) <u>Shady Side Md</u>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>MAY 31/1957</u>		22b. DATE THEREOF	
22c. NAME OF CEMETERY OR CREMATORY <u>CEDAR BLUFF</u>		22d. LOCATION (City, town, or county) (State) <u>ANNAPOLIS MD.</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>JOHN M. TAYLOR - SON</u>		ADDRESS <u>ANNAPOLIS MD.</u>	
24a. REC'D BY REGISTRAR <u>5/31/57</u>		24b. REGISTRAR'S SIGNATURE <u>J. D. Church</u>	

BUREAU V. S.

JUN 3 1957

RECEIVED

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

## MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

04809

## CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <b>Anne Arundel</b>		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE <b>Maryland</b> b. COUNTY <b>Baltimore City</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Crownsville</b>		c. LENGTH OF STAY IN 1b <b>4yrs.3mos.11days</b>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>Crownsville State Hospital</b>		d. STREET ADDRESS <b>1424 Madison Street</b>	
3. NAME OF DECEASED (Type or print) First <b>Unabell</b> Middle <b>Ruffin</b> Last <b>Ruffin</b>		4. DATE OF DEATH Month <b>5</b> Day <b>29</b> Year <b>1957</b>	
5. SEX <b>Female</b>	6. COLOR OR RACE <b>Negro</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>5/29/12</b>
9. AGE (In years last birthday) <b>44</b> yrs.		10. IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Wool Presser</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Unk.</b>	
11. BIRTHPLACE (State or foreign country) <b>Virginia</b>		12. CITIZEN OF WHAT COUNTRY? <b>U. S.</b>	
13. FATHER'S NAME <b>Frank Ruffin?</b>		14. MOTHER'S MAIDEN NAME <b>Mary Lee Burns</b>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <b>Unk.</b>		16. SOCIAL SECURITY NO. <b>Unk.</b>	
17. INFORMANT <b>State Hospital</b>		18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Renal Failure</b> <b>442X</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <b>Hypertensive Cardiovascular-renal disease</b> DUE TO (c) _____	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <b>Decubitus Ulcers 715X</b>		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. p. m. <b>19</b>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <b>3/13</b> , 19 <b>57</b> , to <b>5/29</b> , 19 <b>57</b> , that I last saw the deceased alive on <b>5/29</b> , 19 <b>57</b> , and that death occurred at <b>10:50a.m.</b> from the causes and on the date stated above.			
ACTUAL SIGNATURE <b>Lionel M. Mapp</b>		ADDRESS (Street, city or town, state) <b>Crownsville, Md.</b>	
PHYSICIAN'S NAME (Type) <b>Lionel M. Mapp, M. D.</b>		DATE SIGNED <b>5/29/57</b>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		22b. DATE THEREOF <b>6/3/1957</b>	
22c. NAME OF CEMETERY OF CREMATORY <b>W.F. Coulson Cem</b>		22d. LOCATION (City, town, or county) (State) <b>Balto. Md.</b>	
23. FUNERAL DIRECTOR'S SIGNATURE <b>Mrs Katie R. Williams</b>		ADDRESS <b>Schroeder St.</b>	
24a. REC'D BY REGISTRAR <b>6/3/57</b>		24b. REGISTRAR'S SIGNATURE <b>K. M. Joyce</b>	

7 JUN 4 1957

RECEIVED

04810

## MARYLAND STATE DEPARTMENT OF HEALTH

4821 CERTIFICATE OF DEATH  
FOR MEDICAL EXAMINERS

Reg. Dist. No. 1-3

1. PLACE OF DEATH- COUNTY <b>AA</b>		MARYLAND		2. USUAL RESIDENCE (HOME) OF DECEASED- STATE <b>Maryland</b> COUNTY <b>AA</b>	
CITY (If outside corporate limits, write RURAL and OR give nearest town) <b>Glen Burnie</b>		LENGTH OF STAY (in this place) <b>23.</b>		CITY (If outside corporate limits, write RURAL and give nearest town) <b>Glen Burnie</b>	
HOSPITAL OR INSTITUTION OR STREET ADDRESS <b>656 New Jersey Ave.</b>				STREET ADDRESS (If rural, give location) <b>816 New Jersey Ave. 1</b>	
3. NAME OF DECEASED (Type or Print) <b>Melorn</b> (First) <b>E.</b> (Middle) <b>Saley</b> (Last)		4. DATE OF DEATH <b>5 - 30 - 1957</b> (Month) (Day) (Year)			
5. SEX <b>M</b>	6. COLOR OR RACE <b>White</b>	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) <b>S</b>	8. DATE OF BIRTH <b>OCT. 29, 1924</b>	9. AGE last birthday <b>32</b> yrs.	10. Under 1 year Months Days   11. Under 24 hrs. Hours Mln.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Elec. Technician</b>		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) <b>MARYLAND</b>	
12. CITIZEN OF WHAT COUNTRY? <b>USA</b>		13. FATHER'S NAME <b>James Saley</b>		14. MOTHER'S MAIDEN NAME <b>MARY Gera</b>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY No.		17. INFORMANT AND ADDRESS <b>FAMILY - Same</b>	

## 18. MEDICAL CERTIFICATION

## 1. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH

Immediate cause

(a)

Antecedent cause(s)

Disease or conditions, if any, giving rise to the above cause stating the underlying cause last

(c)

INTERVAL BETWEEN ONSET AND DEATH

## 11. OTHER SIGNIFICANT CONDITIONS

Conditions contributing to the death but not related to the disease or condition causing death.

## 19a. DATE OF OPERATION

## 19b. MAJOR FINDINGS OF OPERATION

## 20. AUTOPSY?

Yes ☐ No ☒

## 21. EXTERNAL CAUSE WAS PRIMARY OR CONTRIBUTING CAUSE OF DEATH

PLACE (Home, farm, factory, street, office bldg., etc.) **Home**(CITY OR TOWN) **Glen Burnie**(COUNTY) **A.A.**(STATE) **Md.**TIME (Month) (Day) (Year) (Hour) OF INJURY **May 30 1957 7:00 P.M.**INJURY OCCURRED While at work ☐ Not while at work ☒HOW DID INJURY OCCUR? **Shot himself in mouth - bullet exited through right temple**22. I certify that I took charge of the remains described above, held an Autopsy ☐, Inspection ☒, Inquiry ☒ thereon and from the evidence obtained by said Autopsy, Inspection or Inquiry, find that said deceased died on the day stated above, and death in my opinion resulted from: natural causes ☐, accident ☐, suicide ☒, homicide ☐, undetermined ☐.

SIGNATURE

(Degree or title)

ADDRESS

DATE SIGNED

## 23. REMOVAL, CREMATION OR BURIAL (Specify)

## DATE THEREOF

## NAME OF CEMETERY OR CREMATORY

## LOCATION (City, town, or county)

(State)

## DATE REC'D BY LOCAL REG.

## REGISTRAR'S SIGNATURE

## 24. FUNERAL DIRECTOR

## ADDRESS

MARGIN RESERVED FOR BINDING

PLEASE WRITE MAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct use of this form is especially important. Physicians: please write the causes of death clearly and legibly.



RECEIVED

JUN 4 1957

BUREAU V. S.

# MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

## MEDICAL EXAMINER'S CERTIFICATE OF DEATH

04811

Reg. Dist. No.

4822

1. PLACE OF DEATH a. COUNTY <u>Anne Arundel</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If Institution; Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Anne Arundel</u>				
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Pasadena P. O.</u>			c. LENGTH OF STAY IN 1b <u>approx 2 hrs.</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Brooklyn Hgts., Balto. 25, Md.</u>			
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>Stoney Creek - Riviera Beach</u>				d. STREET ADDRESS <u>318 Audrey Avenue</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		
3. NAME OF DECEASED (Type or print) First <u>Donald</u> Middle <u>Lee</u> Last <u>Schaeffer</u>				4. DATE OF DEATH Month <u>May</u> Day <u>26</u> Year <u>1957</u>				
5. SEX <u>Male</u>		6. COLOR OR RACE <u>White</u>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>10-3-42</u>		
9. AGE (In years last birthday) <u>14</u> yrs.		IF UNDER 1 YEAR Months <u>  </u> Days <u>  </u>		IF UNDER 24 HRS. Hours <u>  </u> Min. <u>  </u>				
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Attending school</u>			10b. KIND OF BUSINESS OR INDUSTRY <u>---</u>		11. BIRTHPLACE (State or foreign country) <u>Gatesville, Texas</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>William Lynn Schaeffer</u>				14. MOTHER'S MAIDEN NAME <u>Pearl Haltzner</u>				
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>No</u>		16. SOCIAL SECURITY NO. <u>None</u>		17. INFORMANT <u>Mr. &amp; Mrs. William L. Schaeffer (Parents)</u>				
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Accidental drowning</u> DUE TO <u>929.8</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>  </u> DUE TO (c) <u>  </u>							INTERVAL BETWEEN ONSET AND DEATH <u>Sudden</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. EXTERNAL CAUSE WAS PRIMARY <input checked="" type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.			20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <u>Drowned in 10 ft. of water</u>					
20c. TIME OF INJURY Month, Day, Year <u>5-26 1957</u> Hour <u>2:00</u> p.m.		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input checked="" type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <u>Stoney Creek</u>		20f. (City or town) (County) (State) <u>Pasadena P.O. A. A. Co. Md.</u>		
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and find that death resulted from: Natural causes <input type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined cause <input type="checkbox"/> .								
ACTUAL SIGNATURE <u>Gustave H. Faubert</u>				M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/>		DATE SIGNED		
EXAMINER'S NAME (Type) <u>Gustave H. Faubert, M.D.</u>				ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>				
				DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>		<u>5-26-57</u>		
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>May 29, 1957</u>		22c. NAME OF CEMETERY OR CREMATORY <u>Glen Haven</u>		22d. LOCATION (City, town, or county) (State) <u>Glen Burnie Md</u>		
23. FUNERAL DIRECTOR'S SIGNATURE <u>McCully Funeral Homes</u>				ADDRESS <u>Balto</u>		24a. REC'D BY REGISTRAR <u>29 1957</u>		
				24b. REGISTRAR'S SIGNATURE <u>L. J. Dealy</u>				

MEDICAL CERTIFICATION

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please enclose the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the registrar prior to removal.

MASSACHUSETTS DEPARTMENT OF HEALTH - BATHING IS  
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

RECEIVED  
MAY 29 1957  
BUREAU V. S.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

04812

4784

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>ANNE ARUNDEL</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>MARYLAND</u> b. COUNTY <u>QUEEN ANNES</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>ANNAPOLIS</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>CENTREVILLE</u> 17X22	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>ANNE ARUNDEL GENERAL HOSPITAL</u>		d. STREET ADDRESS	
3. NAME OF DECEASED (Type or print) First <u>HUBREY</u> Middle <u>LEE</u> Last <u>SCHELHOUSE</u>		4. DATE OF DEATH Month <u>MAY</u> Day <u>16</u> Year <u>1957</u>	
5. SEX <u>Male</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>July 8 1934</u>
9. AGE (In years last birthday) <u>22</u> yrs.		IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>TRUCK DRIVER</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>TRUCKING</u>	
11. BIRTHPLACE (State or foreign country) <u>CENTREVILLE MARYLAND</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>WEBSTER SCHELHOUSE</u>		14. MOTHER'S MAIDEN NAME <u>REGINA BOONE</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>No</u> (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. <u>214-32-0993</u>	
17. INFORMANT <u>MR. Webster Schelhouse</u>		Address <u>CENTREVILLE, Md.</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>816 X</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Lead injury, result trauma from auto crash</u> DUE TO (c) <u>58 hrs.</u>			INTERVAL BETWEEN ONSET AND DEATH
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) <input checked="" type="checkbox"/>		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <u>Passenger in automobile involved in crash</u>	
20c. TIME OF INJURY Month, Day, Year <u>May 13 1957</u> Hour <u>12:15</u>		20d. INJURY OCCURRED <u>While at work</u> <input checked="" type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <u>St. of Arnold - A.A.</u>		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>May 13</u> , 1957, to <u>May 16</u> , 1957, that I last saw the deceased alive on <u>May 16</u> , 1957, and that death occurred at <u>11 A.M.</u> from the causes and on the date stated above.			
ACTUAL SIGNATURE <u>Menton T. Waite</u>		DATE SIGNED <u>May 16, 1957</u>	
PHYSICIAN'S NAME (Type) <u>M.D. Cathedral &amp; Dean Sts, Annapolis, Md</u>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>	22b. DATE THEREOF <u>May 18-57</u>	22c. NAME OF CEMETERY OR CREMATORY <u>Crestfield Cemetery</u>	22d. LOCATION (City, town, or county) (State) <u>Centerville Maryland</u>
23. FUNERAL DIRECTOR'S SIGNATURE <u>James H. Batten, Jr. Batten Bros. Centerville, Maryland</u>		24a. REC'D BY REGISTRAR <u>Dr. Wm J. French</u>	24b. REGISTRAR'S SIGNATURE





4823

## CERTIFICATE OF DEATH

04813

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>Anne Arundel</u> MARYLAND			2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Washington, D. C.</u> b. COUNTY		
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Rural - Laurel, Md.</u>			c. LENGTH OF STAY IN TB <u>3 yr.</u>		
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Children's Center, District Training School Laurel, Md.</u>			e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		
3. NAME OF DECEASED (Type or print) First <u>Timothy</u> Middle <u>Sheehan</u> Last			4. DATE OF DEATH Month <u>May</u> Day <u>22</u> Year <u>1957</u>		
5. SEX <u>male</u>	6. COLOR OR RACE <u>white</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>Nov. 10, 1948</u>		9. AGE (In years last birthday) <u>8</u> yrs.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) <u>Washington, D.C.</u>	
13. FATHER'S NAME <u>John Sheehan</u>			14. MOTHER'S MAIDEN NAME <u>Vivian</u>		
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>no</u>		16. SOCIAL SECURITY NO. <u>-</u>		17. INFORMANTS <u>Address Laurel, Md. District Training School, Children's Center,</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Acute corpulmonale</u> <u>9217</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>aspiration, pneumonitis</u> DUE TO (c) <u>due to vomiting</u>					INTERVAL BETWEEN ONSET AND DEATH <u>12 hours</u>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>3921 chronic otitis media</u>					19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <u>19</u>	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town)	(County)	(State)
21. I certify that I attended the deceased from <u>5/18</u> , 19 <u>57</u> , to <u>5/22</u> , 19 <u>57</u> , that I last saw the deceased alive on <u>5/22</u> , 19 <u>57</u> , and that death occurred at <u>10:45</u> AM, from the causes and on the date stated above. ADDRESS (Street, city or town, state) <u>Children's Center Laurel, Md.</u> DATE SIGNED <u>5/23/57</u>					
ACTUAL SIGNATURE <u>Wildred R. Ehrmantraut M.D.</u>		PHYSICIAN'S NAME (Type) <u>Wildred R. Ehrmantraut M.D.</u> <u>Children's Center Laurel, Md.</u>			
22a. BURIAL, CREMATION, REMOVAL (Specify)	22b. DATE THEREOF	22c. NAME OF CEMETERY OR CREMATORY	22d. LOCATION (City, town, or county) (State)		
<u>Burial</u>	<u>5-25-57</u>	<u>Wash. D.C.</u>	<u>Wash. D.C.</u>		
23. FUNERAL DIRECTOR'S SIGNATURE <u>Robert A. Mattingly</u>		ADDRESS <u>131-11 24th St. N.W.</u>		24. REG. BY REGISTRAR DATE <u>28 1957</u> REGISTRAR'S SIGNATURE <u>Clara H. Shipps</u>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the general director, page 3 should be attached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.



1

## INSTRUCTIONS

**TO ATTENDING PHYSICIAN OR HOSPITAL:** The law requires that the death certificate be executed within 4 hours after death. The bottom copy may be retained by the hospital or attending physician.

**TO FUNERAL DIRECTOR:** The law requires that the death certificate be filed with the registrar within 72 hours after death. After this certificate has been executed by the attending physician and completely filled in by the funeral director, the third copy of this death certificate assembly should be detached for use as a burial transit permit.

VS AISC 1-55 10M

## MARYLAND STATE DEPARTMENT OF HEALTH-BALTIMORE, 18

## CERTIFICATE OF DEATH

4785

JUN 05 1957

Reg. Dist. No. ....

1. PLACE OF DEATH				2. USUAL RESIDENCE (HOME) OF DECEASED			
COUNTY <u>217</u>		MARYLAND		STATE <u>MD</u>		COUNTY <u>AA</u>	
CITY (If outside corporate limits, write RURAL OR and give nearest town)		LENGTH OF STAY (in this place)		CITY (If outside corporate limits, write RURAL and give nearest town)			
TOWN <u>Annapolis</u>		<u>45 YRS</u>		TOWN <u>Owensville Md.</u>			
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>A. A. Freyer</u>				STREET ADDRESS (If rural give location)			
3. NAME OF DECEASED (Type or Print)				4. DATE OF DEATH			
(First) (Middle) (Last) <u>George Thomas Sherbert</u>				(Month) (Day) (Year) <u>May 30 1957</u>			
5. SEX	6. COLOR OR RACE	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify)	8. DATE OF BIRTH	9. AGE last birthday	IF UNDER 1 YEAR		IF UNDER 24 HRS.
<u>M</u>	<u>White</u>	<u>Single</u>	<u>Aug 21 1894</u>	<u>62</u> yrs.	Months	Days	Hours
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country)		12. CITIZEN OF WHAT COUNTRY?	
<u>Former</u>		<u>Tobacco</u>		<u>Edgewater Md.</u>			
13. FATHER'S NAME				14. MOTHER'S MAIDEN NAME			
<u>William Sherbert</u>				<u>MARY E BAKER</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unk.)		16. SOCIAL SECURITY NO.		17. INFORMANT & ADDRESS			
(If Yes, give war or dates of service)		<u>218 36 1912</u>		<u>John A. Nofel, Sodley MD</u>			
18. MEDICAL CERTIFICATION						INTERVAL BETWEEN ONSET AND DEATH	
I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH							
204.0 IMMEDIATE CAUSE (A) <u>leukemia Leukemia</u>							
ANTECEDENT CAUSE(S) DUE TO							
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST. DUE TO							
(C)							
11 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.							
19a. DATE OF OPERATION		19b. MAJOR FINDINGS OF OPERATION		20. AUTOPSY?		YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)		21c. WHERE DID INJURY OCCUR? (City or town) (County) (State)			
21d. TIME OF INJURY (Month) (Day) (Year) (Hour)		21e. INJURY OCCURRED White <input type="checkbox"/> Not white <input type="checkbox"/> M. <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		21f. HOW DID INJURY OCCUR?			
22. I hereby certify that I attended the deceased from <u>April</u> , 19 <u>57</u> , to <u>May 30</u> , 19 <u>57</u> , that I last saw the deceased alive on <u>May 30</u> , 19 <u>57</u> , and that death occurred at <u>9:05 P.M.</u> from the causes and on the date stated above.							
SIGNATURE <u>Emil H. Wilson</u>				ADDRESS (Street, city, town, state) <u>Crofton, Md</u>		DATE SIGNED <u>6-2-57</u>	
23. BURIAL, CREMATION, REMOVAL (Specify)		DATE THEREOF		NAME OF CEMETERY OR CREMATORY		LOCATION (City, town, or county) (State)	
<u>Burial</u>		<u>6/2/57</u>		<u>Hope Chapel</u>		<u>Edgewater Md</u>	
24. REC'D BY REGISTRAR		REGISTRAR'S SIGNATURE		25. FUNERAL DIRECTOR'S SIGNATURE		ADDRESS	
DATE <u>6/10/57</u>		<u>J. Daniel</u>		<u>Benjamin Hardy</u>		<u>Edgewater Md</u>	



TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.  
TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.

VS. AISME(S)  
5M 9/55

BALTIMORE STATE DEPARTMENT OF HEALTH—BALTIMORE, 18											
MEDICAL EXAMINER'S CERTIFICATE OF DEATH											
Reg. Dist. No. 04814											
1. PLACE OF DEATH a. COUNTY <i>AA</i> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If Institution: Residence before admission) a. STATE <i>Md.</i> b. COUNTY <i>AA</i>							
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Annapolis</i>				c. LENGTH OF STAY IN 1b				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>10 Annapolis</i>			
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <i>A A General Hosp</i>				d. STREET ADDRESS <i>160 Maryland Ave</i>				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>			
3. NAME OF DECEASED (Type or print) <i>First Middle Last</i> <i>Karen Lee Simmons</i>				4. DATE OF DEATH Month <i>5</i> Day <i>24</i> Year <i>1957</i>							
5. SEX <i>Female</i>		6. COLOR OR RACE <i>White</i>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <i>4-3-1957</i>		9. AGE (In years last birthday) <i>1</i> yrs. <i>1</i> month <i>21</i> days <i>1</i> hour <i>1</i> min.		IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>none</i>				10b. KIND OF BUSINESS OR INDUSTRY <i>none</i>				11. BIRTHPLACE (State or foreign country) <i>Annapolis Md</i>		12. CITIZEN OF WHAT COUNTRY? <i>U.S.A.</i>	
13. FATHER'S NAME <i>Richard L. Simmons</i>				14. MOTHER'S MAIDEN NAME <i>Georgia Lee Bowen</i>							
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <i>—</i>				16. SOCIAL SECURITY NO. <i>—</i>				17. INFORMANT <i>Richard L. Simmons</i> Address <i>(2)</i>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>921.0</i> DUE TO <i>Aspiration Vomitus</i> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <i>Aspiration Vomitus</i> DUE TO (c) <i>Aspiration Vomitus</i> INTERVAL BETWEEN ONSET AND DEATH <i>Instant</i>											
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>											
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING CAUSE OF DEATH. <input type="checkbox"/>				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <i>Child possibly vomited and aspirated same</i>							
20c. TIME OF INJURY Month, Day, Year <i>May 5/24/57</i> a. m. <i>5</i> p. m. <i>24</i>				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <i>Home</i>		20f. (City or town) <i>AA.</i> (County) (State)			
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input type="checkbox"/> Inquiry <input type="checkbox"/> and find that death resulted from: Natural causes <input type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined cause <input type="checkbox"/> .											
ACTUAL SIGNATURE <i>E. Linhardt</i>				M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/>				DATE SIGNED <i>8/24/57</i>			
EXAMINER'S NAME (Type) <i>E. Linhardt</i>				ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>							
				DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>							
22a. BURIAL, CREMATION, REMOVAL (Specify) <i>Burial</i>		22b. DATE THEREOF <i>5-26-57</i>		22c. NAME OF CEMETERY OR CREMATORY <i>Hellarest</i>				22d. LOCATION (City, town, or county) <i>Annapolis Md</i> (State)			
23. FUNERAL DIRECTOR'S SIGNATURE <i>John M. Taylor Sons</i>				ADDRESS <i>Annapolis Md</i>				24a. REC'D BY REGISTRAR <i>5/27/57</i>		24b. REGISTRAR'S SIGNATURE <i>Mr. J. French</i>	

2063171XV5



MASSACHUSETTS DEPARTMENT OF HEALTH  
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

RECEIVED  
MAY 28 1957  
BUREAU V. 3

1

## INSTRUCTIONS

**TO ATTENDING PHYSICIAN OR HOSPITAL:** The law requires that the death certificate be executed within 24 hours after death. The bottom copy may be retained by the hospital or attending physician.

**TO FUNERAL DIRECTOR:** The law requires that the death certificate be filed with the registrar within 72 hours after death. After this certificate has been executed by the attending physician and completely filled in by the funeral director, the third copy of this death certificate assembly should be detached for use as a burial transit permit.

VS AISC 1-55 10M

MARYLAND STATE DEPARTMENT OF HEALTH-BALTIMORE, 18

04815

## 4824 CERTIFICATE OF DEATH

Reg. Dist. No. 24

<b>1. PLACE OF DEATH</b>		<b>2. USUAL RESIDENCE (HOME) OF DECEASED</b>	
COUNTY <u>ANNE ARUNDEL</u>	STATE <u>Maryland</u>	COUNTY <u>1</u>	
CITY (If outside corporate limits, write RURAL and give nearest town) <u>GLEN BURNIE</u>	LENGTH OF STAY (in this place)	CITY (If outside corporate limits, write RURAL and give nearest town) <u>Baltimore</u>	
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>PLAZA MANOR CONV. HOME</u>	STREET ADDRESS (If rural give location) <u>1526 Chesapeake Ave.</u>	<u>3701.4</u>	
<b>3. NAME OF DECEASED</b> (First) (Middle) (Last)		<b>4. DATE OF DEATH</b> (Month) (Day) (Year)	
<u>FORD</u> <u>SIMPSON</u>		<u>May 19</u> <u>1957</u>	
<b>5. SEX</b> <u>M</u>	<b>6. COLOR OR RACE</b> <u>C</u>	<b>7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify)</b> <u>Widowed</u>	<b>8. DATE OF BIRTH</b> <u>March</u>
<b>9. AGE last birthday</b> <u>68</u> yrs.	<b>10. KIND OF BUSINESS OR INDUSTRY</b>	<b>11. BIRTHPLACE (State or foreign country)</b> <u>South Carolina</u>	<b>12. CITIZEN OF WHAT COUNTRY?</b> <u>U.S.A.</u>
<b>10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)</b> <u>Laborer</u>	<b>10b. KIND OF BUSINESS OR INDUSTRY</b>	<b>11. BIRTHPLACE (State or foreign country)</b> <u>South Carolina</u>	<b>12. CITIZEN OF WHAT COUNTRY?</b> <u>U.S.A.</u>
<b>13. FATHER'S NAME</b> <u>Frank Simpson</u>		<b>14. MOTHER'S MAIDEN NAME</b> <u>Catherine Latimore</u>	
<b>15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unk.)</b> <u>No</u>		<b>16. SOCIAL SECURITY NO.</b> <u>215-61-2655</u>	
<b>17. INFORMANT &amp; ADDRESS</b> <u>Family - 1526 Chesapeake Ave.</u>			
<b>18. MEDICAL CERTIFICATION</b>			<b>INTERVAL BETWEEN ONSET AND DEATH</b>
<b>I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH</b>			
331X IMMEDIATE CAUSE (A) <u>CEREBROVASCULAR ACCIDENT</u>			
ANTECEDENT CAUSE(S) DUE TO (B) <u>ARTERIO SCLEROSIS GENERAL</u>			
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST. DUE TO (C) <u>450.0</u>			
<b>II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.</b>			
<b>19a. DATE OF OPERATION</b>	<b>19b. MAJOR FINDINGS OF OPERATION</b>		<b>20. AUTOPSY?</b> YES <input type="checkbox"/> NO <input type="checkbox"/>
<b>21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)</b>	<b>21b. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)</b>	<b>21c. WHERE DID INJURY OCCUR? (City or town) (County) (State)</b>	
<b>21d. TIME OF INJURY (Month) (Day) (Year) (Hour) (M.)</b>	<b>21e. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/></b>	<b>21f. HOW DID INJURY OCCUR?</b>	
<b>22. I hereby certify that I attended the deceased from <u>May 16, 1957</u>, to <u>May 19, 1957</u>, that I last saw the deceased alive on <u>May 16, 1957</u>, and that death occurred at <u>6:00 P.M.</u> from the causes and on the date stated above.</b>			
<b>SIGNATURE</b> <u>Joseph Taler</u>		<b>DATE SIGNED</b> <u>5-19-57</u>	
<b>23. BURIAL, CREMATION, REMOVAL (SPECIFY)</b> <u>Burial</u>		<b>24. REC'D BY REGISTRAR</b> <u>Louis J. Neal</u>	
<b>DATE THEREOF</b> <u>May 23, 1957</u>		<b>NAME OF CEMETERY OR CREMATORY</b> <u>Mt. Calvary Cemetery</u>	
<b>REGISTRAR'S SIGNATURE</b> <u>Louis J. Neal</u>		<b>LOCATION (City, town, or county) (State)</b> <u>d. d. Co. Md.</u>	
<b>25. FUNERAL DIRECTOR'S SIGNATURE</b> <u>Robert E. Williams</u>		<b>ADDRESS</b> <u>1701 N. Bond St.</u>	

# CERTIFICATE OF DEATH

Form 10-1-56

1. NAME OF DECEASED

2. SEX

3. AGE

4. DATE OF BIRTH

5. PLACE OF BIRTH

6. DATE OF DEATH

7. PLACE OF DEATH

8. TIME OF DEATH

9. CAUSE OF DEATH

10. MANNER OF DEATH

11. SIGNATURE OF PHYSICIAN

12. SIGNATURE OF REGISTRAR

13. SIGNATURE OF WITNESSES

14. SIGNATURE OF DECEASED

15. SIGNATURE OF NEXT OF KIN

16. SIGNATURE OF CLERGYMAN

17. SIGNATURE OF BURIAL OFFICIAL

18. SIGNATURE OF INTERVIEWER

19. SIGNATURE OF INTERVIEWER

20. SIGNATURE OF INTERVIEWER

21. SIGNATURE OF INTERVIEWER

22. SIGNATURE OF INTERVIEWER

23. SIGNATURE OF INTERVIEWER

24. SIGNATURE OF INTERVIEWER

25. SIGNATURE OF INTERVIEWER

26. SIGNATURE OF INTERVIEWER

27. SIGNATURE OF INTERVIEWER

28. SIGNATURE OF INTERVIEWER

29. SIGNATURE OF INTERVIEWER

30. SIGNATURE OF INTERVIEWER

BUREAU V. 4

1957

RECEIVED

UNRECORDED

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please enclose the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.

VS. A15ME(5)  
5M 9/55

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18										04816
MEDICAL EXAMINER'S CERTIFICATE OF DEATH										Reg. Dist. No. 24
1. PLACE OF DEATH a. COUNTY <u>Anne Arundel</u> MARYLAND					2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Md</u> b. COUNTY					
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Glenburnie</u>			c. LENGTH OF STAY IN 1b		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Balt</u> 31014					
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address)					d. STREET ADDRESS <u>119 W Barne St</u>			e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>		
3. NAME OF DECEASED (Type or print) First <u>Sumner</u> Middle <u>Smith</u> Last <u>Smith</u>					4. DATE OF DEATH Month <u>May</u> Day <u>25</u> Year <u>1957</u>					
5. SEX <u>m</u>		6. COLOR OR RACE <u>C</u>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>6-15-1916</u>		9. AGE (In years last birthday) <u>40</u> yrs.		
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Labr</u>					10b. KIND OF BUSINESS OR INDUSTRY <u>Trucking</u>			11. BIRTHPLACE (State or foreign country) <u>Ala</u>		
13. FATHER'S NAME <u>Will Smith</u>					14. MOTHER'S MAIDEN NAME <u>Gertude Volstead</u>					
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown)					16. SOCIAL SECURITY NO.		17. INFORMANT <u>Gertude Smith</u> Address <u>119 W Barne St</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>3<sup>rd</sup> Degree Burns 100% of Body</u> 816 X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>										
20a. EXTERNAL CAUSE WAS PRIMARY <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.					20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <u>Burned in auto-truck collision</u>					
20c. TIME OF INJURY Month, Day, Year Hour <u>12:32</u> P. M. <u>5/24/57</u>			20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input checked="" type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <u>street</u>		20f. (City or town) <u>Millersville</u>		(County) <u>Anne Arundel</u> (State) <u>Md.</u>	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and find that death resulted from: Natural causes <input type="checkbox"/> , Accident <input checked="" type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined cause <input type="checkbox"/> .										
ACTUAL SIGNATURE <u>William J. Smith</u> M.D.					CHIEF MEDICAL EXAMINER <input type="checkbox"/>					
EXAMINER'S NAME (Type)					ASSISTANT MEDICAL EXAMINER <input checked="" type="checkbox"/>					
					DEPUTY MEDICAL EXAMINER <input type="checkbox"/>					
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Buried</u>					22b. DATE THEREOF <u>5/28/57</u>		22c. NAME OF CEMETERY OR CREMATORY <u>mt Auburn St</u>		22d. LOCATION (City, town, or county) (State) <u>Balt City</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Isaiah L Brown</u>					ADDRESS <u>108 W Montgomery St</u>		24a. REC'D BY REGISTRAR <u>L. J. Deakley</u>		24b. REGISTRAR'S SIGNATURE <u>5/25/57</u>	

MASSACHUSETTS DEPARTMENT OF HEALTH - BOSTON  
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

Form with multiple sections for medical history, cause of death, and examiner information. Includes fields for name, age, sex, date of death, and place of death. There are also checkboxes for various conditions and a section for the medical examiner's signature and seal.

RECEIVED  
MAY 29 1957  
BUREAU V. E.



4826

# CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <b>Anne Arundel</b>		MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Maryland</b>		b. COUNTY <b>Wicomico</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Crownsville</b>		c. LENGTH OF STAY IN 1b <b>10mos. 4days</b>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Delmar 22x02</b>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>Crownsville State Hospital</b>				d. STREET ADDRESS <b>Not given</b>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print)		First <b>Willis</b>		Middle <b>K.</b>		Last <b>Smith</b>	
5. SEX <b>Male</b>		6. COLOR OR RACE <b>Negro</b>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <b>Not given</b>	
9. AGE (In years last birthday) <b>70?</b>		10. IF UNDER 1 YEAR Months <b>-</b> Days <b>-</b> Hours <b>-</b> Min. <b>-</b>		11. IF UNDER 24 HRS. Months <b>-</b> Days <b>-</b> Hours <b>-</b> Min. <b>-</b>		12. DATE OF DEATH <b>5 1 19 57</b>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Not given</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>- - -</b>		11. BIRTHPLACE (State or foreign country) <b>Maryland</b>		12. CITIZEN OF WHAT COUNTRY? <b>U. S.</b>	
13. FATHER'S NAME <b>Thadeus Smith</b>				14. MOTHER'S MAIDEN NAME <b>Josephine Duncan</b>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>Unk.</b>		16. SOCIAL SECURITY NO. (If yes, give war or dates of service) <b>Unk.</b>		17. INFORMANT <b>Hospital Records</b>		Address <b>Crownsville State Hospital Crownsville, Md.</b>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Pulmonary edema</b> <b>420.0</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <b>Arteriosclerotic heart disease with left and right heart failure, emaciation</b> DUE TO (c) <b>right heart failure, emaciation</b>							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <b>Bronchial asthma, decubitus ulcers, scrotal hernia, dehydration</b>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)		20c. TIME OF INJURY Hour a. p. m. <b>19</b>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town)		(County)		(State)	
21. I certify that I attended the deceased from <b>6/27</b> , 19 <b>56</b> , to <b>5/1</b> , 19 <b>57</b> , that I last saw the deceased alive on <b>4/30</b> , 19 <b>57</b> , and that death occurred at <b>12:05 AM</b> , from the causes and on the date stated above. ADDRESS (Street, city or town, state) <b>Crownsville, Md.</b> DATE SIGNED <b>5/1/57</b>							
ACTUAL SIGNATURE <b>[Signature]</b>		M.D. <b>K. Benedict, M. D.</b>		PHYSICIAN'S NAME (Type)			
22a. BURIAL, CREMATION, REMOVAL (Specify)		22b. DATE THEREOF <b>5/5/57</b>		22c. NAME OF CEMETERY OR CREMATORY <b>Gladys Hill</b>		22d. LOCATION (City, town, or county) (State) <b>Parsonburg, Md</b>	
23. FUNERAL DIRECTOR'S SIGNATURE <b>Boaker M. West</b>		ADDRESS <b>130 Second St</b>		24. REC'D BY REGISTRAR <b>MAY 8 1957</b>		25. REGISTRAR'S SIGNATURE <b>[Signature]</b>	

**HOSPITAL OR ATTENDING PHYSICIAN:** The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

**FUNERAL DIRECTOR:** After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be attached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with the registrar price of burial, cremation, or removal, and in any event within 72 hours after death.

VS A15 (4)  
15M 9/55

CERTIFICATE OF DEATH

1234

NAME OF DECEASED		AGE		SEX		RACE		DATE OF BIRTH		PLACE OF BIRTH	
JAMES H. SMITH		45		M		W		JAN 15 1880		BALTIMORE, MD	
RESIDENCE		OCCUPATION		CAUSE OF DEATH		MANNER OF DEATH		DATE OF DEATH		PLACE OF DEATH	
1234 E. MAIN ST.		LABORER		HEART DISEASE		NATURAL		MAY 10 1925		BALTIMORE, MD	
PREVIOUS ILLNESS		MEDICAL ATTENDANCE		POST-MORTEM EXAMINATION		SIGNATURE OF PHYSICIAN		SIGNATURE OF REGISTRAR		DATE OF REGISTRATION	
NONE		YES		NO		J. H. SMITH, M.D.		J. H. SMITH, M.D.		MAY 10 1925	
FAMILY HISTORY		EDUCATION		RELIGION		MARRIAGE		CHILDREN		REMARKS	
NONE		HIGH SCHOOL		METHODIST		MARRIED		3		NONE	

BUREAU V. S.

MAY 6 1925

RECEIVED

1

INSTRUCTIONS

**TO ATTENDING PHYSICIAN OR HOSPITAL:** The law requires that the death certificate be executed within 24 hours after death. The bottom copy may be retained by the hospital or attending physician.

**TO FUNERAL DIRECTOR:** The law requires that the death certificate be filed with the registrar within 72 hours after death. After this death certificate has been executed by the attending physician and completely filled in by the funeral director, the third copy of this death certificate assembly should be detached for use as a burial transit permit.

VS AISC 1-55 10M

## MARYLAND STATE DEPARTMENT OF HEALTH-BALTIMORE, 18

04818

## 4827 CERTIFICATE OF DEATH

Reg. Dist. No. 24

<b>1. PLACE OF DEATH</b>				<b>2. USUAL RESIDENCE (HOME) OF DECEASED</b>			
COUNTY <i>Ann Arundel</i>		MARYLAND		STATE <i>Maryland</i>		COUNTY <i>Ann Arundel</i>	
CITY (If outside corporate limits, write RURAL and give nearest town) <i>Glen Burnie</i>		LENGTH OF STAY (in this place) <i>9 yrs</i>		CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Glen Burnie</i>			
HOSPITAL OR INSTITUTION OR STREET ADDRESS <i>600 Crain Highway</i>				STREET ADDRESS (If rural give location) <i>600 Crain Highway</i>			
<b>3. NAME OF DECEASED</b> (Type or Print) <i>Oliver Henry Snyder Sr.</i>				<b>4. DATE OF DEATH</b> (Month) <i>May</i> (Day) <i>9</i> (Year) <i>1957</i>			
5. SEX <i>Male</i>	6. COLOR OR RACE <i>White</i>	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) <i>Married</i>	8. DATE OF BIRTH <i>Nov. 5, 1888</i>	9. AGE last birthday <i>68</i> yrs.	IF UNDER 1 YEAR Months <i>—</i> Days <i>—</i>		IF UNDER 24 MRS. Hours <i>—</i> Min. <i>—</i>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>Geesey man</i>		10b. KIND OF BUSINESS OR INDUSTRY <i>Same</i>		11. BIRTHPLACE (State or foreign country) <i>Maryland</i>		12. CITIZEN OF WHAT COUNTRY <i>U.S.A.</i>	
13. FATHER'S NAME <i>Thomas William Snyder</i>				14. MOTHER'S MAIDEN NAME <i>Henrietta Reeside</i>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unk.) <i>No</i>		16. SOCIAL SECURITY NO. <i>None</i>		17. INFORMANT & ADDRESS <i>Naomi Brown 3001 Ohio Balto 27, Md</i>			
<b>18. MEDICAL CERTIFICATION</b>						INTERVAL BETWEEN ONSET AND DEATH	
I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH							
334X IMMEDIATE CAUSE (A) <i>Respiratory Failure</i>						<i>20 min.</i>	
ANTECEDENT CAUSE(S) DUE TO (B) <i>Cerebral Degeneration</i>						<i>4 mos</i>	
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST, DUE TO (C) <i>Cerebral Arteriosclerosis</i>						<i>5 yrs.</i>	
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH. <i>Obesity</i>						<i>10 yrs.</i>	
19a. DATE OF OPERATION		19b. MAJOR FINDINGS OF OPERATION				20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)		21c. WHERE DID INJURY OCCUR? (City or town) (County) (State)			
21d. TIME OF INJURY (Month) (Day) (Year) (Hour) (Min.)		21e. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> et work <input type="checkbox"/> et work <input type="checkbox"/>		21f. HOW DID INJURY OCCUR?			
22. I hereby certify that I attended the deceased from <i>11/2</i> 19 <i>48</i> , to <i>5/9</i> 19 <i>57</i> , that I last saw the deceased alive on <i>5/9</i> 19 <i>57</i> , and that death occurred at <i>11:30</i> M, from the causes and on the date stated above.							
SIGNATURE <i>J. W. Prichard</i>				ADDRESS (Street, city, town, state) <i>715 Coater Rd Glen Burnie Md 21043</i>			
23. BURIAL, CREMATION, REMOVAL (SPECIFY) <i>BURIAL</i>		DATE THEREOF <i>5/13/57</i>		NAME OF CEMETERY OR CREMATORY <i>LOUWONT PARK</i>		LOCATION (City, town, or county) (State) <i>FREDERICK AVE</i>	
24. REC'D BY REGISTRAR DATE <i>5/13/57</i>		REGISTRAR'S SIGNATURE <i>Louis J. DeAlba</i>		25. FUNERAL DIRECTOR'S SIGNATURE <i>GEORGE M. BALIT</i>		ADDRESS <i>525 LYNDA HURST ST</i>	

# CERTIFICATE OF DEATH

FILE NO. 12

1. NAME OF DECEASED: [REDACTED]

2. SEX: [REDACTED]

3. AGE: [REDACTED]

4. DATE OF BIRTH: [REDACTED]

5. PLACE OF BIRTH: [REDACTED]

6. OCCUPATION: [REDACTED]

7. CAUSE OF DEATH: [REDACTED]

8. DATE OF DEATH: [REDACTED]

9. PLACE OF DEATH: [REDACTED]

10. SIGNATURE OF DECEASED: [REDACTED]

11. SIGNATURE OF WITNESS: [REDACTED]

12. SIGNATURE OF PHYSICIAN: [REDACTED]

13. SIGNATURE OF CORONER: [REDACTED]

14. SIGNATURE OF JURY: [REDACTED]

15. SIGNATURE OF JUDGE: [REDACTED]

16. SIGNATURE OF CLERK: [REDACTED]

17. SIGNATURE OF REGISTRAR: [REDACTED]

18. SIGNATURE OF DECEASED: [REDACTED]

19. SIGNATURE OF WITNESS: [REDACTED]

20. SIGNATURE OF PHYSICIAN: [REDACTED]

21. SIGNATURE OF CORONER: [REDACTED]

22. SIGNATURE OF JURY: [REDACTED]

23. SIGNATURE OF JUDGE: [REDACTED]

24. SIGNATURE OF CLERK: [REDACTED]

25. SIGNATURE OF REGISTRAR: [REDACTED]

26. SIGNATURE OF DECEASED: [REDACTED]

27. SIGNATURE OF WITNESS: [REDACTED]

28. SIGNATURE OF PHYSICIAN: [REDACTED]

BUREAU V. E.

MAY 18 1957

RECEIVED

12 MONTHS

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be attached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

## MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

04819

4828

## CERTIFICATE OF DEATH

Reg. Dist. No. 20

1. PLACE OF DEATH o. COUNTY <u>Anne Arundel</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE <u>Maryland</u> b. COUNTY <u>Anne Arundel</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Brooklyn Hgts.</u>		c. LENGTH OF STAY IN 1b <u>4 mos.</u>	
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>50 Brooklyn Hgts.</u>		d. STREET ADDRESS <u>410 Seward Ave.</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>410 Seward Ave.</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <u>William Thomas Spencer</u>		4. DATE OF DEATH Month <u>May</u> Day <u>15</u> , Year <u>1957</u>	
5. SEX <u>Male</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>May 18, 1885</u>
9. AGE (In years last birthday) yrs. <u>71</u>		IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Acid Maker Ret.</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Chemical</u>	
11. BIRTHPLACE (State or foreign country) <u>Philadelphia, Pa.</u>		12. CITIZEN OF WHAT COUNTRY? <u>U. S.</u>	
13. FATHER'S NAME <u>James Spencer</u>		14. MOTHER'S MAIDEN NAME <u>Catherine Mannion</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO.	
17. INFORMANT <u>Elizabeth K. Spencer</u>		Address <u>410 Seward Ave.</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Cerebro Vascular Accident - left</u> <u>442X</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <u>Pulmonary Edema, A.S.C. r.H. R.D.</u> DUE TO (c) <u>1 hr.</u>		INTERVAL BETWEEN ONSET AND DEATH	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>331X</u>		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <u>19</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>6-18</u> , 19 <u>54</u> , to <u>15 May</u> , 19 <u>57</u> , that I last saw the deceased alive on <u>13 May</u> , 19 <u>57</u> , and that death occurred at <u>11 A</u> M, from the causes and on the date stated above.			
ACTUAL SIGNATURE <u>Andrew R. Sosnowski</u> M.D.		ADDRESS (Street, city or town, state) DATE SIGNED <u>4016 Gov. Ritchie Hgwy. May 16, 1957</u>	
PHYSICIAN'S NAME (Type) <u>Andrew R. Sosnowski M. D.</u>		<u>4016 Gov. Ritchie Hgwy May 16, 1957</u>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>May 18, 1957</u>	
22c. NAME OF CEMETERY OR CREMATORY <u>Holy Cross Cem.</u>		22d. LOCATION (City, town, or county) (State) <u>Ritchie Hgwy. A. A. Co., Md.</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>George J. Gorce</u>		ADDRESS <u>4001 Ritchie Hgwy.</u>	
24a. REC'D BY REGISTRAR DATE <u>5/21/57</u>		24b. REGISTRAR'S SIGNATURE <u>Leda Whitely</u>	



BUREAU OF THE ARMY

1957 22 MAY

RECEIVED

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be attached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18  
Item 7 Film 0216 5-29-57 et  
CERTIFICATE OF DEATH

04820

Reg. Dist. No. 15

4829

1. PLACE OF DEATH a. COUNTY AA MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY AA	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Greenland Beach		c. LENGTH OF STAY IN 1b Yrs.	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION 116 Weldon Rd.		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Middle Last Leonard Squires		4. DATE OF DEATH Month Day Year 5 22 57 19	
5. SEX M	6. COLOR OR RACE W	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 8/26/04
9. AGE (In years last birthday) 52 yrs.		10. IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Foreman		10b. KIND OF BUSINESS OR INDUSTRY Gibson & Kirk	
11. BIRTHPLACE (State or foreign country) Baltimore, Md.		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME George Squires		14. MOTHER'S MAIDEN NAME Margaret Hoppie	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) No		16. SOCIAL SECURITY NO.	
17. INFORMANT Family		Address Same	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 156.1 Carcinoma Liver DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Generalized Metastases DUE TO (c)		INTERVAL BETWEEN ONSET AND DEATH 1 year 2 months	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Nat while of work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from 3/23, 1957, to 4/22, 1957, that I last saw the deceased alive on 4/21, 1957, and that death occurred at 5:00 AM, from the causes and on the date stated above.			
ACTUAL SIGNATURE J. Brady Smith		ADDRESS (Street, city or town, state) Riviera Beach	
PHYSICIAN'S NAME (Type) J. BRADY SMITH		DATE SIGNED 5/22/57	
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 5/25/57	
22c. NAME OF CEMETERY OR CREMATORY Glen Haven Cem.		22d. LOCATION (City, town, or county) (State) Glen Burnie, Md.	
23. FUNERAL DIRECTOR'S SIGNATURE McCully Funeral Homes 130 E. Fort Ave. # 30		24a. REC'D BY REGISTRAR DATE 5/24/57	
24b. REGISTRAR'S SIGNATURE Eda Whitford			

1957

RECEIVED

1

## INSTRUCTIONS

**TO ATTENDING PHYSICIAN OR HOSPITAL:** The law requires that the death certificate be executed within 72 hours after death. The bottom copy shall be retained by the hospital or attending physician.

**TO FUNERAL DIRECTOR:** The law requires that the death certificate be filed with the registrar within 72 hours after death. After this certificate has been executed by the attending physician and completely filled in by the funeral director, the third copy of this death certificate assembly should be detached for use as a burial transit permit.

VS AISC 1-55 10M

MARYLAND STATE DEPARTMENT OF HEALTH-BALTIMORE, 18

04821

## CERTIFICATE OF DEATH

4830

Reg. Dist. No. ....

<b>1. PLACE OF DEATH</b>				<b>2. USUAL RESIDENCE (HOME) OF DECEASED</b>			
COUNTY <u>ANNE ARUNDEL</u> MARYLAND				STATE <u>Maryland</u> COUNTY			
CITY (If outside corporate limits, write RURAL and give nearest town) TOWN <u>GLEN BURNIE</u>				CITY (If outside corporate limits, write RURAL and give nearest town) TOWN <u>Baltimore</u> <u>3V01-4</u>			
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>PLAZA MANOR CONV. HOME</u>				STREET ADDRESS (If rural give location) <u>906 Saratoga Street</u>			
<b>3. NAME OF DECEASED</b> (Type or Print) <u>Bessie E. TALBott</u>				<b>4. DATE OF DEATH</b> (Month) <u>May</u> (Day) <u>8</u> (Year) <u>1957</u>			
<b>5. SEX</b> <u>F</u>	<b>6. COLOR OR RACE</b> <u>C</u>	<b>7. SINGLE, MARRIED, WIDOWED, DIVORCED</b> (Specify) <u>Widow</u>	<b>8. DATE OF BIRTH</b> <u>6-27-1885</u>		<b>9. AGE last birthday</b> <u>71</u> yrs.	<b>IF UNDER 1 YEAR</b> Months <u>11</u> Days <u>12</u>	
<b>10a. USUAL OCCUPATION</b> (Give kind of work done during most of working life, even if retired) <u>Domestic</u>				<b>10b. KIND OF BUSINESS OR INDUSTRY</b> <u>Pvt. Family</u>		<b>11. BIRTHPLACE</b> (State or foreign country) <u>Lancaster, Va.</u>	
<b>12. CITIZEN OF WHAT COUNTRY?</b> <u>U.S.A.</u>							
<b>13. FATHER'S NAME</b> <u>Pernius Conway</u>				<b>14. MOTHER'S MAIDEN NAME</b> <u>Siner Pinkney</u>			
<b>15. WAS DECEASED EVER IN U. S. ARMED FORCES?</b> (Yes, no, or unk.) <u>NO</u> (If Yes, give war or dates of service)				<b>16. SOCIAL SECURITY NO.</b>		<b>17. INFORMANT &amp; ADDRESS</b> <u>Plaza Manor Conv. Home - Glen Burnie</u>	
<b>I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH</b>						<b>18. MEDICAL CERTIFICATION</b>	
<b>260x IMMEDIATE CAUSE (A)</b> <u>CEREBROVASCULAR ACCIDENT</u>						<b>INTERVAL BETWEEN ONSET AND DEATH</b>	
<b>ANTECEDENT CAUSE(S) DUE TO (B)</b> <u>ARTERIOSCLEROSIS GENERAL</u>							
<b>DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST, DUE TO (C)</b> <u>Diabetes mellitus</u>							
<b>II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.</b>							
<b>19a. DATE OF OPERATION</b> <u>331X</u>				<b>19b. MAJOR FINDINGS OF OPERATION</b>			
<b>21a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)</b>				<b>21b. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)</b>		<b>21c. WHERE DID INJURY OCCUR?</b> (City or town) (County) (State)	
<b>21d. TIME OF INJURY</b> (Month) (Day) (Year) (Hour) (Minute) <u>3:15P</u>				<b>21e. INJURY OCCURRED</b> While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		<b>21f. HOW DID INJURY OCCUR?</b>	
<b>22. I hereby certify that I attended the deceased from Oct 1955, to May 8, 1957, that I last saw the deceased alive on May 8, 1957, and that death occurred at 3:15P M, from the causes and on the date stated above.</b>							
<b>SIGNATURE</b> <u>Charles R. Law</u> M.D.				<b>ADDRESS</b> (Street, city, town, state) <u>Baltimore, Md. 58-5</u>		<b>DATE SIGNED</b>	
<b>23. BURIAL, CREMATION, REMOVAL (SPECIFY)</b> <u>Burial</u>		<b>DATE THEREOF</b> <u>5-9-57</u>		<b>NAME OF CEMETERY OR CREMATORY</b> <u>Mt. Auburn</u>		<b>LOCATION</b> (City, town, or county) (State) <u>Baltimore, Maryland</u>	
<b>24. REC'D BY REGISTRAR</b>		<b>REGISTRAR'S SIGNATURE</b> <u>L. J. Seelby</u>		<b>25. FUNERAL DIRECTOR'S SIGNATURE</b> <u>Charles R. Law</u>		<b>ADDRESS</b> <u>802 Madison Avenue</u>	
<b>DATE</b> <u>MAY 10 1957</u>							

TO ATTENDING PHYSICIAN OR HOSPITAL:

TO FUNERAL DIRECTOR:

# CERTIFICATE OF DEATH

1957

Page 1 of 1

1. DECEASED'S NAME (Last, first, middle initial)

2. SEX (Male or Female)

3. AGE (Years, months, days)

4. DATE OF BIRTH

5. PLACE OF BIRTH

6. OCCUPATION

7. MARITAL STATUS

8. EDUCATION

9. RELIGION

10. RACE

11. COLOR

12. ETHNIC ORIGIN

13. SOCIAL CLASS

14. INCOME

15. HEALTH HISTORY

16. PRESENT ILLNESS

17. CAUSE OF DEATH

18. MANNER OF DEATH

19. PLACE OF DEATH

20. TIME OF DEATH

21. SIGNATURE OF DECEASED

22. SIGNATURE OF WITNESSES

23. SIGNATURE OF PHYSICIAN

24. SIGNATURE OF CORONER

25. SIGNATURE OF JURY

26. SIGNATURE OF COURT

27. SIGNATURE OF STATE

28. SIGNATURE OF COUNTY

29. SIGNATURE OF CITY

30. SIGNATURE OF TOWN

31. SIGNATURE OF VILLAGE

32. SIGNATURE OF PARISH

33. SIGNATURE OF PRESTBYTERY

BUREAU V. 3

MAY 10 1957

RECEIVED

INSTRUCTIONS

1. This certificate is to be filled out by the physician or coroner who has examined the body of the deceased and has determined the cause and manner of death. It is to be filled out in duplicate, one copy to be retained by the physician or coroner and the other copy to be forwarded to the State Department of Health, Baltimore, Maryland.

2. The deceased's name should be written in full, including middle initial, and in the order of last, first, and middle initial.

3. The sex should be written as "Male" or "Female".

4. The age should be written in years, months, and days.

5. The date of birth should be written in full, including day, month, and year.

6. The place of birth should be written in full, including city, county, and state.

7. The occupation should be written in full.

8. The marital status should be written as "Married", "Single", "Widowed", or "Divorced".

9. The education should be written in full.

10. The religion should be written in full.

11. The race should be written in full.

12. The color should be written in full.

13. The ethnic or origin should be written in full.

14. The social class should be written in full.

15. The income should be written in full.

16. The health history should be written in full.

17. The present illness should be written in full.

18. The cause of death should be written in full.

19. The manner of death should be written in full.

20. The place of death should be written in full.

21. The time of death should be written in full.

22. The signature of the deceased should be written in full.

23. The signature of the witnesses should be written in full.

24. The signature of the physician should be written in full.

25. The signature of the coroner should be written in full.

26. The signature of the jury should be written in full.

27. The signature of the court should be written in full.

28. The signature of the state should be written in full.

29. The signature of the county should be written in full.

30. The signature of the city should be written in full.

31. The signature of the town should be written in full.

32. The signature of the village should be written in full.

33. The signature of the parish should be written in full.

34. The signature of the presbytery should be written in full.



4831  
CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>Anne Arundel Co.</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>A.A</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Harwood, Md. (Annapolis)</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>X2 Harwood (Annapolis, Md)</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION		d. STREET ADDRESS	
3. NAME OF DECEASED (Type or print) <u>First Baby Middle Thomas Last</u>		4. DATE OF DEATH Month <u>May</u> Day <u>7</u> Year <u>1957</u>	
5. SEX <u>F</u>	6. COLOR OR RACE <u>C</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>May 7 1957</u>
9. AGE (In years last birthday) yrs.		IF UNDER 1 YEAR Months <u>12</u> Days <u>12</u> Hours <u>12</u> Min.	IF UNDER 24 HRS.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10b. KIND OF BUSINESS OR INDUSTRY <u>Edgar &amp; Sons</u>	
10c. BIRTHPLACE (State and foreign country) <u>Maryland</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A</u>	
13. FATHER'S NAME <u>Richard G. Thomas, Jr.</u>		14. MOTHER'S MAIDEN NAME <u>Myra H. Hammond</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown)		16. SOCIAL SECURITY NO. <u>—</u>	
17. INFORMANT <u>Richard Thomas Jr. - Harwood, Md.</u>		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>762.5 Atelectasis</u> DUE TO (b) <u>Premature - 7 mon.</u> DUE TO (c) <u>—</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.			INTERVAL BETWEEN ONSET AND DEATH <u>12 days</u>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m.	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I attended the deceased from <u>5/7</u> , 19 <u>57</u> , to <u>5/7</u> , 19 <u>57</u> , that I last saw the deceased alive on <u>5/7</u> , 19 <u>57</u> , and that death occurred at <u>2 P.</u> M, from the causes and on the date stated above.			
ACTUAL SIGNATURE <u>Theodore H. Johnson</u> , M.D.		DATE SIGNED <u>37 Calvert St</u>	
PHYSICIAN'S NAME (Type) <u>DR. THEODORE H. JOHNSON, JR.</u>		<u>Annapolis, Md.</u>	
22a. BURIAL, CREMATION, REMOVAL (Specify)	22b. DATE THEREOF <u>5-8-57</u>	22c. NAME OF CEMETERY OR CREMATORY <u>Mt Zion</u>	22d. LOCATION (City, town, or county) (State) <u>Lothman, Md.</u>
23. FUNERAL DIRECTOR'S SIGNATURE <u>William Reese, Jr. - Annapolis, Md.</u>		24a. REC'D BY REGISTRAR <u>MAY 10 1957</u>	24b. REGISTRAR'S SIGNATURE <u>Wm. J. French</u>

TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.



4832

## CERTIFICATE OF DEATH

Reg. Dist. No.

04823

1. PLACE OF DEATH a. COUNTY <b>Anne Arundel</b> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Baltimore City</b>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Crownsville</b>				c. LENGTH OF STAY IN 1b <b>1yr. 10mos. 9days</b>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>Crownsville State Hospital</b>				d. STREET ADDRESS <b>916 E. Preston Street</b>			
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>							
3. NAME OF DECEASED (Type or print) First <b>John</b> Middle <b>Thornton</b> Last <b>Thornton</b>				4. DATE OF DEATH Month <b>5</b> Day <b>28</b> Year <b>57</b>			
5. SEX <b>Male</b>		6. COLOR OR RACE <b>Negro</b>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <b>12/4/00</b>	
9. AGE (In years last birthday) <b>56 30</b> yrs.		IF UNDER 1 YEAR Months <b>5</b> Days <b>28</b> Hours <b>57</b> Min.		IF UNDER 24 HRS. Hours <b>57</b> Min.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Laborer</b>				10b. KIND OF BUSINESS OR INDUSTRY <b>Unknown</b>		11. BIRTHPLACE (State or foreign country) <b>Virginia</b>	
12. CITIZEN OF WHAT COUNTRY? <b>U. S.</b>							
13. FATHER'S NAME <b>William Thornton</b>				14. MOTHER'S MAIDEN NAME <b>Mary Thornton</b>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <b>Unk. Unk.</b>				16. SOCIAL SECURITY NO. <b>Unk.</b>			
17. INFORMANT <b>Hospital Records</b>				Address <b>State Hospital Crownsville, Md.</b>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Pulmonary Edema, Pneumonia</b> <b>434.1</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <b>Congestive Heart Failure</b> DUE TO (c)							INTERVAL BETWEEN ONSET AND DEATH
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <b>305X Alzheimer Disease, Epilepsy</b>							19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. p. m. <b>19</b>				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town) (County) (State)							
21. I certify that I attended the deceased from <b>7/19</b> , 19 <b>55</b> , to <b>5/28</b> , 19 <b>57</b> , that I last saw the deceased alive on <b>5/28</b> , 19 <b>57</b> , and that death occurred at <b>12:45 p.m.</b> , from the causes and on the date stated above. ADDRESS (Street, city or town, state) <b>Crownsville, Md.</b> DATE SIGNED <b>5/28/57</b>							
ACTUAL SIGNATURE <b>Ludwig Benedict, M. D.</b>				M.D. <b>Ludwig Benedict, M. D.</b>			
PHYSICIAN'S NAME (Type)							
22a. BURIAL, CREMATION, REMOVAL (Specify)		22b. DATE THEREOF		22c. NAME OF CEMETERY OR CREMATORY		22d. LOCATION (City, town, or county) (State)	
<b>5/31/57</b>		<b>mt Calvary</b>		<b>Anne Arundel Co. Md.</b>			
23. FUNERAL DIRECTOR'S SIGNATURE <b>Randolph Bollick</b>				ADDRESS <b>1412 E. Preston St.</b>		24a. REC'D BY REGISTRAR DATE <b>5/31/57</b>	
24b. REGISTRAR'S SIGNATURE <b>L. M. Joyce</b>							

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

CERTIFICATE OF DEATH

NAME OF DECEASED		SEX		AGE		DATE OF BIRTH		PLACE OF BIRTH		OCCUPATION		CAUSE OF DEATH	
JAMES H. HARRIS		Male		40		1917		BALTIMORE, MARYLAND		LABORER		HEART DISEASE	
DATE OF DEATH		TIME OF DEATH		PLACE OF DEATH		MANNER OF DEATH		CERTIFICATE OF DEATH		SIGNATURE OF REGISTRAR		SIGNATURE OF PHYSICIAN	
JULY 1, 1957		10:00 AM		BALTIMORE, MARYLAND		NATURAL		JAMES H. HARRIS		JAMES H. HARRIS		JAMES H. HARRIS	
DATE OF INTERMENT		TIME OF INTERMENT		PLACE OF INTERMENT		MANNER OF INTERMENT		CERTIFICATE OF INTERMENT		SIGNATURE OF REGISTRAR		SIGNATURE OF PHYSICIAN	
JULY 3, 1957		10:00 AM		BALTIMORE, MARYLAND		NATURAL		JAMES H. HARRIS		JAMES H. HARRIS		JAMES H. HARRIS	

RECEIVED  
JUN 3 1957  
BUREAU V. S.

TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be attached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

## MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

04824

4833

## CERTIFICATE OF DEATH

Reg. Dist. No.

28

1. PLACE OF DEATH o. COUNTY <b>Anne Arundel</b> <b>MARYLAND</b>				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE <b>Maryland</b> b. COUNTY <b>Baltimore City</b>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Crownsville</b>				c. LENGTH OF STAY IN 1b <b>7yrs.5mos.6days</b>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Baltimore City</b> <b>3401.4</b> ✓	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>Crownsville State Hospital</b>				d. STREET ADDRESS <b>818 Tyson Street</b>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Middle Last <b>Evelyn Mae Tinsley</b>				4. DATE OF DEATH Month Day Year <b>5 27 19 57</b>			
5. SEX <b>Female</b>		6. COLOR OR RACE <b>Negro</b>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <b>1/22/15</b>	
9. AGE (In years last birthday) yrs. <b>42</b>		10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Not given</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>- - - -</b>		11. BIRTHPLACE (State or foreign country) <b>Maryland</b>	
13. FATHER'S NAME <b>Thomas Tinsley</b>				14. MOTHER'S MAIDEN NAME <b>Katie Chase</b>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>Unk.</b>		16. SOCIAL SECURITY NO. <b>Unk.</b>		17. INFORMANT <b>Hospital Records</b>		Address <b>Crownsville State Hospital Crownsville, Maryland</b>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Pulmonary Tuberculosis, Far advanced</b> <b>002X</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <b>Epilepsy 353.3</b>						INTERVAL BETWEEN ONSET AND DEATH	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour o. m. <b>19</b>				20d. INJURY OCCURRED While of work <input type="checkbox"/> Not while of work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town) (County) (State)				20f. (City or town) (County) (State)			
21. I certify that I attended the deceased from <b>July 12, 1956</b> to <b>May 27, 1957</b> , that I last saw the deceased alive on <b>May 27, 1957</b> , and that death occurred at <b>10:32p</b> M, from the causes and on the date stated above.							
ACTUAL SIGNATURE <b>Lionel McHenry Mapp</b>				ADDRESS (Street, city or town, state) <b>Crownsville, Md.</b>			
PHYSICIAN'S NAME (Type) <b>Lionel McHenry Mapp, M. D.</b>				DATE SIGNED <b>5/28/57</b>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Removal</b>		22b. DATE THEREOF <b>6/1/57</b>		22c. NAME OF CEMETERY OR CREMATORY <b>Mt. Zion</b>		22d. LOCATION (City, town, or county) (State) <b>Baltimore, Md.</b>	
23. FUNERAL DIRECTOR'S SIGNATURE <b>Charles B. Lewis</b>				ADDRESS <b>1639 N. Beardsley Balt., Md.</b>		24a. REC'D BY REGISTRAR DATE <b>5/29/57</b>	
24b. REGISTRAR'S SIGNATURE <b>H. M. Joyce</b>							



CERTIFICATE OF DEATH

1. NAME OF DECEASED		2. SEX		3. AGE	
4. PLACE OF BIRTH		5. DATE OF BIRTH		6. DATE OF DEATH	
7. PLACE OF DEATH		8. CAUSE OF DEATH		9. MANNER OF DEATH	
10. OCCUPATION		11. EDUCATION		12. RELIGION	
13. MARITAL STATUS		14. SOCIAL STATUS		15. RACE	
16. PREVIOUS ILLNESS		17. PRESENT ILLNESS		18. MEDICAL HISTORY	
19. PHYSICIAN'S SIGNATURE		20. CORONER'S SIGNATURE		21. REGISTRAR'S SIGNATURE	
22. ADDRESS		23. CITY		24. STATE	
25. ZIP CODE		26. COUNTY		27. DISTRICT	
28. WARD		29. PARISH		30. CHURCH	
31. BURIAL PLACE		32. GRAVE		33. TOMB	
34. MONUMENT		35. INSCRIPTION		36. OTHER	
37. REMARKS		38. SIGNATURE		39. DATE	
40. TIME		41. PLACE		42. OTHER	
43. SIGNATURE		44. DATE		45. OTHER	
46. SIGNATURE		47. DATE		48. OTHER	
49. SIGNATURE		50. DATE		51. OTHER	
52. SIGNATURE		53. DATE		54. OTHER	
55. SIGNATURE		56. DATE		57. OTHER	
58. SIGNATURE		59. DATE		60. OTHER	
61. SIGNATURE		62. DATE		63. OTHER	
64. SIGNATURE		65. DATE		66. OTHER	
67. SIGNATURE		68. DATE		69. OTHER	
70. SIGNATURE		71. DATE		72. OTHER	
73. SIGNATURE		74. DATE		75. OTHER	
76. SIGNATURE		77. DATE		78. OTHER	
79. SIGNATURE		80. DATE		81. OTHER	
82. SIGNATURE		83. DATE		84. OTHER	
85. SIGNATURE		86. DATE		87. OTHER	
88. SIGNATURE		89. DATE		90. OTHER	
91. SIGNATURE		92. DATE		93. OTHER	
94. SIGNATURE		95. DATE		96. OTHER	
97. SIGNATURE		98. DATE		99. OTHER	
100. SIGNATURE		101. DATE		102. OTHER	

RECEIVED  
MAY 31 1957  
BUREAU V. 8

MASSACHUSETTS DEPARTMENT OF HEALTH - BOSTON  
RECEIVED  
MAY 31 1957  
BUREAU V. 8

1

## INSTRUCTIONS

**TO ATTENDING PHYSICIAN OR HOSPITAL:** The law requires that the death certificate be executed within 72 hours after death. The bottom copy may be retained by the hospital or attending physician.

**TO FUNERAL DIRECTOR:** The law requires that the death certificate be filed with the registrar within 72 hours after death. After this certificate has been executed by the attending physician and completely filled in by the funeral director, the third copy of this death certificate assembly should be detached for use as a burial transit permit.

VS A15C 1-55 10M

MARYLAND STATE DEPARTMENT OF HEALTH-BALTIMORE, 18

## CERTIFICATE OF DEATH

04825

4834

Reg. Dist. No. ....

<b>1. PLACE OF DEATH</b>				<b>2. USUAL RESIDENCE (HOME) OF DECEASED</b>			
COUNTY <u>aa</u>		MARYLAND		STATE <u>md</u>		COUNTY <u>aa</u>	
CITY (If outside corporate limits, write RURAL and give nearest town) TOWN <u>Harwood</u>		LENGTH OF STAY (in this place) <u>51 yrs</u>		CITY (If outside corporate limits, write RURAL and give nearest town) TOWN <u>Harwood</u>			
HOSPITAL OR INSTITUTION OR STREET ADDRESS				STREET ADDRESS (If rural give location) <u>1</u>			
<b>3. NAME OF DECEASED</b> (Type or Print) (First) (Middle) (Last) <u>Mary Elizabeth Tongue</u>				<b>4. DATE OF DEATH</b> (Month) (Day) (Year) <u>8-3-1957</u>			
5. SEX <u>Female</u>	6. COLOR OR RACE <u>Colored</u>	7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify) <u>Single</u>	8. DATE OF BIRTH <u>Nov 28 1905</u>	9. AGE last birthday <u>51</u> yrs.	IF UNDER 1 YEAR Months Days		IF UNDER 24 HRS. Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>none</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>none</u>		11. BIRTHPLACE (State or foreign country) <u>Harwood Md.</u>		12. CITIZEN OF WHAT COUNTRY?	
13. FATHER'S NAME <u>Richard W. Tongue</u>				14. MOTHER'S MAIDEN NAME <u>Hester Moveland</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unk.) <u>no</u>		16. SOCIAL SECURITY NO. <u>none</u>		17. INFORMANT & ADDRESS <u>Hester Tongue, Harwood Md.</u>			
<b>I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH</b>						INTERVAL BETWEEN ONSET AND DEATH	
170x IMMEDIATE CAUSE (A) <u>Carcinoma breast</u>							
ANTECEDENT CAUSE(S) DUE TO							
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST, DUE TO							
(C)							
<b>II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.</b>							
19a. DATE OF OPERATION		19b. MAJOR FINDINGS OF OPERATION				20. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)		21c. WHERE DID INJURY OCCUR? (City or town) (County) (State)			
21d. TIME OF INJURY (Month) (Day) (Year) (Hour) M.		21e. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		21f. HOW DID INJURY OCCUR?			
<b>22. I hereby certify</b> that I attended the deceased from <u>June</u> , 19 <u>48</u> , to <u>May 3</u> , 19 <u>57</u> ; that I last saw the deceased alive on <u>April 30</u> , 19 <u>57</u> , and that death occurred at <u>3:40 P.M.</u> from the causes and on the date stated above. SIGNATURE <u>Emily H. Wilson</u> M.D. <u>Lathrop, Md</u> ADDRESS (Street, city, town, state) <u>West Rock Md.</u> DATE SIGNED <u>8-3-57</u>							
23. BURIAL, CREMATION, REMOVAL (SPECIFY) <u>Buried</u>		DATE THEREOF <u>5/1/57</u>		NAME OF CEMETERY OR CREMATORY <u>Chew's</u>		LOCATION (City, town, or county) (State) <u>West Rock Md.</u>	
24. REC'D BY REGISTRAR <u>JO - J. J. J.</u>		REGISTRAR'S SIGNATURE		25. FUNERAL DIRECTOR'S SIGNATURE <u>Bernard Hardisty Gilwell</u>		ADDRESS	
DATE							

BUREAU V. J.

MAY 9 1957

RECEIVED

100

4787

## CERTIFICATE OF DEATH

Reg. Dist. No. 21

1. PLACE OF DEATH a. COUNTY <u>Anne Arundel</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE <u>Maryland</u> b. COUNTY <u>Calvert</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Annapolis</u>				c. LENGTH OF STAY IN 1b			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Anne Arundel County Hospital</u>				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First <u>Owen</u> Middle <u>Alonzo</u> Last <u>Tower</u>				4. DATE OF DEATH Month <u>May</u> Day <u>10</u> Year <u>1957</u>			
5. SEX <u>male</u>		6. COLOR OR RACE <u>white</u>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>August 17, 1871</u>	
9. AGE (In years last birthday) <u>85</u> yrs.		IF UNDER 1 YEAR Months <u>  </u> Days <u>  </u> Hours <u>  </u> Min. <u>  </u>		IF UNDER 24 HRS. Months <u>  </u> Days <u>  </u> Hours <u>  </u> Min. <u>  </u>			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)				10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) <u>Maryland</u>	
12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>							
13. FATHER'S NAME <u>Alonzo E. Tower</u>				14. MOTHER'S MAIDEN NAME <u>Margaret Roberts</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown)				16. SOCIAL SECURITY NO. (If yes, give year or dates of service)		17. INFORMANT Address <u>Mrs. Rosalie Della, Route #3, Box 28, Pasadena, Md</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Coronary artery disease</u> 420.1 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>  </u> DUE TO (c) <u>  </u> PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>776.2 C. &amp; H. urinary retention</u> INTERVAL BETWEEN ONSET AND DEATH <u>6 wks.</u>							
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. <u>  </u> p. m. <u>  </u> 19 <u>  </u>				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town)				20g. (County)		20h. (State)	
21. I certify that I attended the deceased from <u>5/2</u> , 19 <u>57</u> , to <u>5/10</u> , 19 <u>57</u> , that I last saw the deceased alive on <u>5/10</u> , 19 <u>57</u> , and that death occurred at <u>2:30</u> P.M. from the causes and on the date stated above. ADDRESS (Street, city or town, state) <u>  </u> DATE SIGNED <u>5/10/57</u>							
ACTUAL SIGNATURE <u>John C. Hedgcock</u> M.D.							
PHYSICIAN'S NAME (Type)							
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>5-13-57</u>		22c. NAME OF CEMETERY OR CREMATORY <u>Mt. Carmel Cemetery</u>		22d. LOCATION (City, town, or county) (State) <u>Baltimore</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>William Cook, Inc., 1217 St. Paul Street</u>				24a. REC'D BY REGISTRAR DATE <u>5/13/57</u>		24b. REGISTRAR'S SIGNATURE <u>Dr. Wm. J. French</u>	

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be attached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

CERTIFICATE OF DEATH

NAME OF DECEASED		SEX		AGE		DATE OF BIRTH		PLACE OF BIRTH		MARRIAGE		DATE OF MARRIAGE		PLACE OF MARRIAGE	
OCCUPATION		EDUCATION		RELIGION		RACE		COLOR		HEIGHT		WEIGHT		HAIR	
CAUSE OF DEATH		MANNER OF DEATH		PLACE OF DEATH		DATE OF DEATH		TIME OF DEATH		TEMPERATURE		PULSE		RESPIRATION	
SIGNATURE OF PHYSICIAN		SIGNATURE OF CORONER		SIGNATURE OF JURY		SIGNATURE OF WITNESSES		SIGNATURE OF DECEASED		SIGNATURE OF NEXT OF KIN		SIGNATURE OF CLERGY		SIGNATURE OF OTHER	
DATE OF DEATH		TIME OF DEATH		PLACE OF DEATH		MANNER OF DEATH		CAUSE OF DEATH		SIGNATURE OF PHYSICIAN		SIGNATURE OF CORONER		SIGNATURE OF JURY	

BUREAU V. 2

NOV 14 1957

RECEIVED



MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

4788

CERTIFICATE OF DEATH

Reg. Dist. No.

04827

1. PLACE OF DEATH o. COUNTY <u>MARYLAND</u>				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE <u>Maryland</u> b. COUNTY <u>Anne Arundel</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Annapolis</u>				c. LENGTH OF STAY IN 1b <u>Davidsonville</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Anne Arundel General Hospital</u>				d. STREET ADDRESS		e. IS RESIDENCE ON A FARM? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Middle Last <u>DANIEL WEBSTER TOWNSHEND JR.</u>				4. DATE OF DEATH Month Day Year <u>May 24 1957</u>			
5. SEX <u>Male</u>		6. COLOR OR RACE <u>White</u>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/>		8. DATE OF BIRTH <u>May 31, 1881</u>	
9. AGE (In years last birthday) <u>75 yrs.</u>		10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Foreman- saw mill</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Lumber</u>		11. BIRTHPLACE (State or foreign country) <u>A.A. County, Maryland</u>	
12. CITIZEN OF WHAT COUNTRY? <u>USA</u>		13. FATHER'S NAME <u>Daniel W. Townshend</u>		14. MOTHER'S MAIDEN NAME <u>Martha S. Bealle</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>no</u>		16. SOCIAL SECURITY NO. <u>214-03-9981</u>		17. INFORMANT Address <u>Mrs Marice King- Daughter- Same as # 2</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Cerebral Thrombosis?</u> 153X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <u>Cerebral Arteriosclerosis</u> DUE TO (c) <u>Polio</u>						INTERVAL BETWEEN ONSET AND DEATH <u>One yr</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>332X</u>						19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <u>19</u>		20d. INJURY OCCURRED While of work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>May 1957</u> to <u>May 24 1957</u> , that I last saw the deceased alive on <u>May 24 1957</u> , and that death occurred at <u>PM</u> , from the causes and on the date stated above.							
ACTUAL SIGNATURE <u>Elmer G Linhardt</u>				ADDRESS (Street, city or town, state) <u>Chesapeake Ave Annapolis, Maryland</u>		DATE SIGNED <u>5-25-57</u>	
PHYSICIAN'S NAME (Type) <u>Elmer G Linhardt MD</u>							
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>May 27, 57</u>		22c. NAME OF CEMETERY OR CREMATORY <u>All Hallows Chapel Cemetery</u>		22d. LOCATION (City, town, or county) (State) <u>Davidsonville, Maryland</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Hopping Funeral Home</u>				ADDRESS <u>Annapolis, Maryland</u>		24a. REC'D BY REGISTRAR DATE <u>MAY 28 1957</u>	
24b. REGISTRAR'S SIGNATURE <u>Thos J French</u>							

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

CERTIFICATE OF DEATH

1957

Form with multiple sections for death certificate, including fields for name, date, and location. The text is mirrored and difficult to read.

BUREAU V. S.

MAY 28 1957

RECEIVED

Form with fields for date, time, and location, likely for recording the death.

# MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

## MEDICAL EXAMINER'S CERTIFICATE OF DEATH

04828

4835

Reg. Dist. No. 21

1. PLACE OF DEATH a. COUNTY <u>ANNE ARUNDEL</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>VA</u> b. COUNTY			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>1 mile north of Bloody</u>				c. LENGTH OF STAY IN 1b		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Norfolk</u> 83X-3	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>Point Light</u>				d. STREET ADDRESS <u>5437 Powhatan Ave</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <u>HAROLD</u> Middle <u>F</u> Last <u>TWEEDY</u>				4. DATE OF DEATH Month <u>5</u> Day <u>11</u> Year <u>1957</u>			
5. SEX <u>XX</u>		6. COLOR OR RACE <u>W</u>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>1-30-1899</u>	
9. AGE (In years last birthday) <u>57</u> yrs.		10. IF UNDER 1 YEAR Months <u>5</u> Days <u>11</u>		11. IF UNDER 24 HRS. Hours <u>19</u> Min. <u>57</u>			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Cook</u>				10b. KIND OF BUSINESS OR INDUSTRY <u>Esso Steamship</u>		11. BIRTHPLACE (State or foreign country) <u>Conn.</u>	
12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>							
13. FATHER'S NAME <u>Henry Tweedy</u>				14. MOTHER'S MAIDEN NAME <u>Laura Chester</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>yes</u> (If yes, give year or dates of service) <u>WW I</u>				16. SOCIAL SECURITY NO.		17. INFORMANT <u>M. Giles - Standard Oil Co.</u> Address	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>DROWNED, FOUND DROWNED</u> <u>929.9</u> DUE TO Conditions, if any, which gave rise to immediate cause (b) (c), stating the underlying cause lost. DUE TO							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Hour <u>19</u> o. m. p. m.		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> Inspection <input type="checkbox"/> Inquiry <input type="checkbox"/> and find that death resulted from: Natural causes <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined cause <input checked="" type="checkbox"/>							
ACTUAL SIGNATURE <u>Paul F. Guerin</u>				M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/>			
EXAMINER'S NAME (Type) <u>PAUL F. GUERIN</u>				ASSISTANT MEDICAL EXAMINER <input checked="" type="checkbox"/>			
				DEPUTY MEDICAL EXAMINER <input type="checkbox"/>			
22a. BURIAL, CREMATION, REMOVAL (Specify)		22b. DATE THEREOF <u>5-15-57</u>		22c. NAME OF CEMETERY OR CREMATORY <u>Elmwood Cem</u>		22d. LOCATION (City, town, or county) (State) <u>Norfolk VA</u>	
22. FUNERAL DIRECTOR'S SIGNATURE <u>McCully Funeral Homes</u>				ADDRESS <u>5/22/57</u>		24a. REC'D BY REGISTRAR <u>Dr. Wm J. French</u>	
				24b. REGISTRAR'S SIGNATURE			

MEDICAL CERTIFICATION

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please enclose the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.

MASSACHUSETTS STATE DEPARTMENT OF HEALTH - BOSTON  
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

BUREAU V. 9

1957

RECEIVED

## CERTIFICATE OF DEATH

04829

Reg. Dist. No. 27

4836

1. PLACE OF DEATH a. COUNTY <u>Anne Arundel</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Anne Arundel</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Fort George G. Meade</u>				c. LENGTH OF STAY IN 1b <u>12 hrs 8 min</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>U. S. Army Hospital</u>				d. STREET ADDRESS <u>Ridge Road</u>			
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
3. NAME OF DECEASED (Type or print) First Middle Last <u>CAROL ANN WARFEL</u>				4. DATE OF DEATH Month <u>May</u> Day <u>5</u> Year <u>1957</u>			
5. SEX <u>Female</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>5 May 1957</u>		9. AGE (In years last birthday) yrs. <u>5</u>	IF UNDER 1 YEAR Months <u>12</u> Days <u>8</u>	IF UNDER 24 HRS. Hours <u>12</u> Min. <u>8</u>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>None</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>None</u>		11. BIRTHPLACE (State or foreign country) <u>Maryland</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13. FATHER'S NAME <u>Charles Garfield Warfel, Jr.</u>				14. MOTHER'S MAIDEN NAME <u>Lois Ann Warnick</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>No</u>		16. SOCIAL SECURITY NO. (If yes, give war or dates of service) <u>None</u>		17. INFORMANT <u>Father, Rt #1, Box 84, Hanover, Maryland</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Subarachnoid hemorrhage, extensive</u> 771.5 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Prematurity</u> DUE TO (c) _____						INTERVAL BETWEEN ONSET AND DEATH <u>12 hrs 8 min</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) _____						19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. _____		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>5 MAY</u> , 19 <u>57</u> to <u>5 MAY</u> , 19 <u>57</u> , that I last saw the deceased alive on <u>5 MAY</u> , 19 <u>57</u> , and that death occurred at <u>2:20</u> P.M., from the causes and on the date stated above.							
ACTUAL SIGNATURE <u>Capt. A. Fiascone</u>				ADDRESS (Street, city or town, state) DATE SIGNED <u>USAH Ft Geo</u>			
PHYSICIAN'S NAME (Type) <u>ARNOLD D. FIASCONE, Capt, MC, USAH, Ft Geo. G. Meade, Maryland</u>							
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Cremation</u>		22b. DATE THEREOF <u>6 May 57</u>		22c. NAME OF CEMETERY OR CREMATORY <u>Removed to Medical Lab.</u>		22d. LOCATION (City, town, or county) (State) <u>Fort George G. Meade, Md.</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>LOUIS F. OETTINGER, CWO, USA</u>				24a. REC'D BY REGISTRAR <u>W.L. Saylor</u>		24b. REGISTRAR'S SIGNATURE <u>W.L. Saylor, 1st Lt, MSC.</u>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

2050233XVI



CERTIFICATE OF DEATH

1. Name of deceased John Doe		2. Sex Male		3. Age 45	
4. Date of death May 10, 1957		5. Time of death 10:30 AM		6. Place of death Home	
7. Cause of death Heart disease		8. Immediate cause Myocardial infarction		9. Underlying cause Coronary artery disease	
10. Manner of death Natural		11. Physician's name Dr. J. H. Smith		12. Signature of physician J. H. Smith	
13. Name of informant John Doe		14. Relationship to deceased Son		15. Signature of informant John Doe	
16. Date of birth May 10, 1912		17. Place of birth Maryland		18. Race White	
19. Marital status Married		20. Occupation Teacher		21. Education High School	
22. Previous illness None		23. Habits None		24. Other remarks None	

RECEIVED  
MAY 10 1957  
BUREAU V. S.

4837

CERTIFICATE OF DEATH

Reg. Dist. No.

28

1. PLACE OF DEATH a. COUNTY <b>Anne arundel</b> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Baltimore City</b>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Crownsville</b>				c. LENGTH OF STAY IN 1b <b>1 yr. 2 mos. 10 days</b>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>Crownsville State Hospital</b>				d. STREET ADDRESS <b>1510 Argyle Avenue</b>			
3. NAME OF DECEASED (Type or print) First <b>Moses</b> Middle <b>Charles</b> Last <b>Waters</b>				4. DATE OF DEATH Month <b>5</b> Day <b>26</b> Year <b>19 57</b>			
5. SEX <b>Male</b>		6. COLOR OR RACE <b>Negro</b>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <b>2/12/02?</b>	
9. AGE (In years last birthday) <b>55?</b> yrs.		IF UNDER 1 YEAR Months <b>55?</b> Days <b>55?</b> Hours <b>55?</b> Min. <b>55?</b>		IF UNDER 24 HRS. Months <b>55?</b> Days <b>55?</b> Hours <b>55?</b> Min. <b>55?</b>			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Laborer</b>				10b. KIND OF BUSINESS OR INDUSTRY <b>Unknown</b>		11. BIRTHPLACE (State or foreign country) <b>Maryland</b>	
13. FATHER'S NAME <b>Moses Waters</b>				14. MOTHER'S MAIDEN NAME <b>Mary Waters</b>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>unk.</b> (If yes, give war or dates of service) <b>unk.</b>				16. SOCIAL SECURITY NO. <b>Unk.</b>		17. INFORMANT <b>Hospital Records</b>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Syphilitic and Arteriosclerotic Cardiovascular Disease</b> DUE TO (b) <b>023 X</b> DUE TO (c) <b>023 X</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost.				INTERVAL BETWEEN ONSET AND DEATH			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <b>332 X Softening of the brain</b>				19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <b>19</b>				20d. INJURY OCCURRED While of work <input type="checkbox"/> Not while of work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town) (County) (State)							
21. I certify that I attended the deceased from <b>3/16</b> , 19 <b>56</b> , to <b>5/26</b> , 19 <b>57</b> , that I last saw the deceased alive on <b>5/26</b> , 19 <b>57</b> , and that death occurred at <b>7:50 P.M.</b> , from the causes and on the date stated above.							
ACTUAL SIGNATURE <b>[Signature]</b>				ADDRESS (Street, city or town, state) <b>Crownsville, Md.</b> DATE SIGNED <b>5/27/57</b>			
PHYSICIAN'S NAME (Type) <b>Ludwig Benedict, M. D.</b>							
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		22b. DATE THEREOF <b>5/31/57</b>		22c. NAME OF CEMETERY OR CREMATORY <b>Crownsville State Hospital</b>		22d. LOCATION (City, town, or county) (State) <b>Crownsville, Maryland</b>	
23. FUNERAL DIRECTOR'S SIGNATURE <b>Ralph H. May</b> ADDRESS <b>Crownsville, Md.</b>				24a. REC'D BY REGISTRAR <b>5/31/57</b>		24b. REGISTRAR'S SIGNATURE <b>[Signature]</b>	



MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

CERTIFICATE OF DEATH

04831

Reg. Dist. No.

4789

1. PLACE OF DEATH o. COUNTY <u>aa</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE <u>md</u> b. COUNTY <u>aa</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Annapolis</u>				c. LENGTH OF STAY IN 1b <u>10</u> <u>Annapolis</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>715 Chesapeake Ave</u>				d. STREET ADDRESS <u>715 Chesapeake Ave</u>			
3. NAME OF DECEASED (Type or print) First <u>Charles</u> Middle <u>G.</u> Last <u>Weber</u>				4. DATE OF DEATH Month <u>5</u> Day <u>27</u> Year <u>1957</u>			
5. SEX <u>Male</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>July 10<sup>th</sup> 1885</u>	9. AGE (In years lost birthday) <u>71</u> yrs.	IF UNDER 1 YEAR Months Days Hours Min.		IF UNDER 24 HRS.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Engineer City Annapolis Md</u>				10b. KIND OF BUSINESS OR INDUSTRY <u>Engineer</u>		11. BIRTHPLACE (State or foreign country) <u>Austin Texas</u>	
12. CITIZEN OF WHAT COUNTRY? <u>U. S. A</u>				13. FATHER'S NAME <u>Emil Weber</u>			
14. MOTHER'S MAIDEN NAME <u>_____</u>				15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>YES.</u> (If yes, give war or dates of service) <u>_____</u>			
16. SOCIAL SECURITY NO. <u>_____</u>				17. INFORMANT <u>MRS. WEBER</u> Address <u>#2</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Cerebral Thrombosis</u> <u>332x</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <u>Cerebral Arteriosclerosis</u> DUE TO (c) <u>_____</u>						INTERVAL BETWEEN ONSET AND DEATH <u>2 days</u> <u>unknown</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (o) 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Hour o. m. p. m. Month, Day, Year <u>19</u>				20d. INJURY OCCURRED While of work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
				20f. (City or town) (County) (State)			
21. I certify that I attended the deceased from <u>FEB</u> , 19 <u>57</u> , to <u>27 MAY</u> , 19 <u>57</u> , that I last saw the deceased alive on <u>27 MAY</u> , 19 <u>57</u> , and that death occurred at <u>12:15 P.M.</u> , from the causes and on the date stated above.							
ACTUAL SIGNATURE <u>Edward Beck</u> M.D.				ADDRESS (Street, city or town, state) <u>41 Southgate Ave Annapolis Md</u>			
DATE SIGNED <u>5/28/57</u>							
PHYSICIAN'S NAME (Type) <u>Annapolis Md</u>							
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>5-30-57</u>		22c. NAME OF CEMETERY OR CREMATORY <u>Cedar Bluff</u>		22d. LOCATION (City, town, or county) (State) <u>Annapolis Md</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>John M. Taylor Sr</u>				ADDRESS <u>Annapolis Md</u>		24a. REC'D BY REGISTRAR DATE <u>5/29/57</u>	
				24b. REGISTRAR'S SIGNATURE <u>10 - Wilson</u>			

# CERTIFICATE OF DEATH

MARYLAND STATE DEPARTMENT OF HEALTH - BALTIMORE, MD

Case No. \_\_\_\_\_

Name of Deceased		Sex		Age		Date of Birth		Place of Birth		Manner of Death		Cause of Death		Date of Death		Time of Death		Place of Death		Signature of Physician		Signature of Registrar	
John Doe		Male		45		1912		Maryland		Natural		Heart Disease		June 3, 1957		10:00 AM		Home		Dr. J. Smith		J. Doe	
Occupation		Marital Status		Education		Religion		Usual Residence		Last Residence		Previous Residence		Previous Residence		Previous Residence		Previous Residence		Previous Residence		Previous Residence	
Teacher		Married		High School		Catholic		123 Main St.		123 Main St.		123 Main St.		123 Main St.		123 Main St.		123 Main St.		123 Main St.		123 Main St.	
Date of Death		Time of Death		Place of Death		Signature of Physician		Signature of Registrar		Signature of Physician		Signature of Registrar		Signature of Physician		Signature of Registrar		Signature of Physician		Signature of Registrar		Signature of Physician	
June 3, 1957		10:00 AM		Home		Dr. J. Smith		J. Doe		Dr. J. Smith		J. Doe		Dr. J. Smith		J. Doe		Dr. J. Smith		J. Doe		Dr. J. Smith	

BUREAU V. S.

JUN 3 1957

RECEIVED



# MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

## MEDICAL EXAMINER'S CERTIFICATE OF DEATH

04832

Reg. Dist. No. 20

4838

<b>1. PLACE OF DEATH</b> a. COUNTY <u>AA. Co.</u> <span style="float: right;">MARYLAND</span>				<b>2. USUAL RESIDENCE</b> (Where deceased lived. If institution: Residence before admission) a. STATE <u>AA. Co.</u> b. COUNTY <u>AA. Co.</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>DAVIDSONVILLE</u>		c. LENGTH OF STAY IN 1b <u>10 yrs</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Davidsonville - XO</u>			
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address)				d. STREET ADDRESS <u>1</u>			
<b>3. NAME OF DECEASED</b> (Type or print) First <u>Charles</u> Middle <u>B</u> Last <u>Wood</u>				<b>4. DATE OF DEATH</b> Month <u>5</u> Day <u>9</u> Year <u>1957</u>			
5. SEX <u>M</u>		6. COLOR OR RACE <u>W</u>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>			
8. DATE OF BIRTH <u>April 16 1933</u>		9. AGE (In years last birthday) <u>24</u> yrs.		IF UNDER 1 YEAR Months <u>24</u> Days <u>24</u>			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>FARMER</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Nutwell nut</u>		11. BIRTHPLACE (State or foreign country) <u>Nutwell nut</u>			
12. CITIZEN OF WHAT COUNTRY? <u>USA</u>				13. FATHER'S NAME <u>ALBERT LEE WOOD</u>			
14. MOTHER'S MAIDEN NAME <u>CLARA R. NOPP</u>				15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>Yes</u>			
16. SOCIAL SECURITY NO. <u>214 30 744</u>				17. INFORMANT <u>ALBERT WOOD DAVIDSONVILLE MD</u>			
<b>18. CAUSE OF DEATH</b> [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Fracture Skull -</u> <u>823X</u> DUE TO <u>Crushing injury to chest</u> Conditions, if any, which gave rise to immediate cause (b) <u>Crushing injury to chest</u> (c), stating the underlying cause last. DUE TO <u>Crushing injury to chest</u> (c) <u>Crushing injury to chest</u>							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>Interval between onset and death</u> <u>Interval between onset and death</u>							
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of Item 18.) <u>Auto accident - Car hit truck</u>					
20c. TIME OF INJURY Month, Day, Year <u>5/9 1957</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input checked="" type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <u>Highway</u>			
20f. (City or town) <u>AA. Co. Md.</u>		(County) (State)					
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input type="checkbox"/> , Inquiry <input type="checkbox"/> , and find that death resulted from Natural causes <input type="checkbox"/> , Accident <input checked="" type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined cause <input type="checkbox"/> .							
ACTUAL SIGNATURE <u>E. Linhart</u>		M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/>		DATE SIGNED <u>5/9/57</u>			
EXAMINER'S NAME (Type) <u>E. Linhart</u>		ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>		DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>5/11/57</u>		22c. NAME OF CEMETERY OR CREMATORY <u>MT Zion</u>			
22d. LOCATION (City, town, or county) <u>40th St. Md.</u>		(State)					
23. FUNERAL DIRECTOR'S SIGNATURE <u>Bernard Hardisty</u>		ADDRESS <u>Salisbury Md.</u>		FILED BY REGISTRAR <u>14 1957</u>			
DATE <u>5/9/57</u>		24. REG. SIGNATURE <u>B. Linhart</u>					

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM-3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.

MASSACHUSETTS STATE DEPARTMENT OF HEALTH - BOSTON  
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

4888

1. NAME OF DECEASED		2. SEX		3. AGE	
4. OCCUPATION		5. MARITAL STATUS		6. PLACE OF BIRTH	
7. DATE OF DEATH		8. TIME OF DEATH		9. PLACE OF DEATH	
10. CAUSE OF DEATH		11. MANNER OF DEATH		12. SIGNATURE OF EXAMINER	
13. SIGNATURE OF WITNESS		14. SIGNATURE OF CORONER		15. SIGNATURE OF JURY	
16. SIGNATURE OF MEDICAL EXAMINER		17. SIGNATURE OF JURY		18. SIGNATURE OF JURY	
19. SIGNATURE OF JURY		20. SIGNATURE OF JURY		21. SIGNATURE OF JURY	
22. SIGNATURE OF JURY		23. SIGNATURE OF JURY		24. SIGNATURE OF JURY	
25. SIGNATURE OF JURY		26. SIGNATURE OF JURY		27. SIGNATURE OF JURY	
28. SIGNATURE OF JURY		29. SIGNATURE OF JURY		30. SIGNATURE OF JURY	
31. SIGNATURE OF JURY		32. SIGNATURE OF JURY		33. SIGNATURE OF JURY	
34. SIGNATURE OF JURY		35. SIGNATURE OF JURY		36. SIGNATURE OF JURY	
37. SIGNATURE OF JURY		38. SIGNATURE OF JURY		39. SIGNATURE OF JURY	
40. SIGNATURE OF JURY		41. SIGNATURE OF JURY		42. SIGNATURE OF JURY	
43. SIGNATURE OF JURY		44. SIGNATURE OF JURY		45. SIGNATURE OF JURY	
46. SIGNATURE OF JURY		47. SIGNATURE OF JURY		48. SIGNATURE OF JURY	
49. SIGNATURE OF JURY		50. SIGNATURE OF JURY		51. SIGNATURE OF JURY	
52. SIGNATURE OF JURY		53. SIGNATURE OF JURY		54. SIGNATURE OF JURY	
55. SIGNATURE OF JURY		56. SIGNATURE OF JURY		57. SIGNATURE OF JURY	
58. SIGNATURE OF JURY		59. SIGNATURE OF JURY		60. SIGNATURE OF JURY	
61. SIGNATURE OF JURY		62. SIGNATURE OF JURY		63. SIGNATURE OF JURY	
64. SIGNATURE OF JURY		65. SIGNATURE OF JURY		66. SIGNATURE OF JURY	
67. SIGNATURE OF JURY		68. SIGNATURE OF JURY		69. SIGNATURE OF JURY	
70. SIGNATURE OF JURY		71. SIGNATURE OF JURY		72. SIGNATURE OF JURY	
73. SIGNATURE OF JURY		74. SIGNATURE OF JURY		75. SIGNATURE OF JURY	
76. SIGNATURE OF JURY		77. SIGNATURE OF JURY		78. SIGNATURE OF JURY	
79. SIGNATURE OF JURY		80. SIGNATURE OF JURY		81. SIGNATURE OF JURY	
82. SIGNATURE OF JURY		83. SIGNATURE OF JURY		84. SIGNATURE OF JURY	
85. SIGNATURE OF JURY		86. SIGNATURE OF JURY		87. SIGNATURE OF JURY	
88. SIGNATURE OF JURY		89. SIGNATURE OF JURY		90. SIGNATURE OF JURY	
91. SIGNATURE OF JURY		92. SIGNATURE OF JURY		93. SIGNATURE OF JURY	
94. SIGNATURE OF JURY		95. SIGNATURE OF JURY		96. SIGNATURE OF JURY	
97. SIGNATURE OF JURY		98. SIGNATURE OF JURY		99. SIGNATURE OF JURY	
100. SIGNATURE OF JURY		101. SIGNATURE OF JURY		102. SIGNATURE OF JURY	

BUREAU V. R.

1957

RECEIVED

TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be attached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A15 (4)  
15M 9/55

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

Item 7 Film 9276 6-10-57 et

4839

CERTIFICATE OF DEATH

04833

Reg. Dist. No. 28

1. PLACE OF DEATH o. COUNTY <b>Anne Arundel</b> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE <b>Maryland</b> b. COUNTY <b>Baltimore City</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Crownsville</b>		c. LENGTH OF STAY IN 1b <b>7yrs.4mos.9days</b>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>Crownsville State Hospital</b>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Baltimore City</b> 3V01.4	
3. NAME OF DECEASED (Type or print) First <b>Edward</b> Middle <b>Young</b> Last <b>Young</b>		4. DATE OF DEATH Month <b>5</b> Day <b>27</b> Year <b>19 57</b>	
5. SEX <b>Male</b>	6. COLOR OR RACE <b>Negro</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>Not given</b>
9. AGE (In years last birthday) <b>60</b> yrs.		10. IF UNDER 1 YEAR Months <b>0</b> Days <b>27</b> Hours <b>0</b> Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Not given</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Not given</b>	
11. BIRTHPLACE (State or foreign country) <b>Not given</b>		12. CITIZEN OF WHAT COUNTRY? <b>Not given</b>	
13. FATHER'S NAME <b>William Young</b>		14. MOTHER'S MAIDEN NAME <b>Not given</b>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>Unk.</b>		16. SOCIAL SECURITY NO. <b>Unk.</b>	
17. INFORMANT <b>Hospital Records</b>		Address <b>Crownsville State Hospital Crownsville, Md.</b>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Septicopyemia</b> <b>521X</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <b>Deep Decubital Ulcers</b> DUE TO (c) <b>Metastatic abscesses in the lungs</b>			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <b>Fracture of mandible, sub-dural hemorrhage</b>			
19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) <b>904.9</b>		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. p. m. <b>19</b>		20d. INJURY OCCURRED While of work <input type="checkbox"/> Not while of work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <b>1/18, 19 50</b> to <b>5/27</b> , 19 <b>57</b> , that I last saw the deceased alive on <b>5/27</b> , 19 <b>57</b> , and that death occurred at <b>4 P.</b> M, from the causes and on the date stated above. ADDRESS (Street, city or town, state) <b>Crownsville, Md.</b> DATE SIGNED <b>5/28/57</b> ACTUAL SIGNATURE <b>Ludwig Benedict, M. D.</b> PHYSICIAN'S NAME (Type)			
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Buried 5-30-57</b>		22b. DATE THEREOF <b>5-30-57</b>	
22c. NAME OF CEMETERY OR CREMATORY <b>Brewer Hill Cemetery</b>		22d. LOCATION (City, town, or county) (State) <b>Annapolis, Md.</b>	
23. FUNERAL DIRECTOR'S SIGNATURE <b>Charles E. Hicken</b>		24a. REC'D BY REGISTRAR <b>5/29/57</b>	
24b. REGISTRAR'S SIGNATURE <b>R. M. Joyce</b>		24c. REGISTRAR'S SIGNATURE <b>R. M. Joyce</b>	

**BUREAU V. S.**

JUN 3 1957

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar for burial, cremation, or removal, and in any event within 72 hours after death.

## MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

4840

## CERTIFICATE OF DEATH

04834

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>Anne Arundel</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE <u>Maryland</u> b. COUNTY	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Crownsville</u>		c. LENGTH OF STAY IN 1b <u>10 mo. 11da.</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Crownsville State</u>		e. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Baltimore</u> <u>3101.4</u>	
3. NAME OF DECEASED (Type or print) First <u>Elizabeth</u> Middle <u>Brown</u> Last <u>Young</u>		4. DATE OF DEATH Month <u>5</u> Day <u>24</u> Year <u>1957</u>	
5. SEX <u>Female</u>	6. COLOR OR RACE <u>Negro</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>12-9-1893</u>
9. AGE (In years last birthday) <u>63</u> yrs.		IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>unemployed</u>		10b. KIND OF BUSINESS OR INDUSTRY -----	
11. BIRTHPLACE (State or foreign country) <u>Maryland</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME -----		14. MOTHER'S MAIDEN NAME -----	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) -----		16. SOCIAL SECURITY NO. -----	
17. INFORMANT <u>Hospital Records</u>		Address <u>Crownsville, Md.</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <u>Uremia and Hypostatic Pneumonia</u> 442X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <u>Hypertensive Cardiovascular-renal Disease</u> DUE TO (c) ----- PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>522X</u> 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) -----	
20c. TIME OF INJURY Month, Day, Year Hour a. m. ----- 19-- p. m. -----		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) -----		20f. (City or town) (County) (State) -----	
21. I certify that I attended the deceased from <u>7-13-56</u> , 19-- to <u>5-24-</u> , 19 <u>57</u> , that I last saw the deceased alive on <u>5-24-57</u> , 19-- and that death occurred at <u>9:10 am</u> , from the causes and on the date stated above. ADDRESS (Street, city or town, state) <u>Crownsville, Maryland</u> DATE SIGNED <u>5-24-57</u> ACTUAL SIGNATURE <u>Lionel McHenry Mapp, M.D.</u> PHYSICIAN'S NAME (Type) <u>Lionel McHenry Mapp, M. D.</u> <u>Crownsville, Maryland</u>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>May 28, 1957</u>	
22c. NAME OF CEMETERY OR CREMATORY <u>Mount Calvary Cemetery</u>		22d. LOCATION (City, town, or county) (State) <u>Brookland, A.A. Co. Md.</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Elroy O. Wilson</u>		24a. REC'D BY REGISTRAR <u>31 1957</u>	
ADDRESS <u>Lionel McHenry Mapp</u>		24b. REGISTRAR'S SIGNATURE <u>L. M. Geyer</u>	



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MAY 31 1957

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